DOCUMENT RESUME

ED 239 439 EC 161 176

AUTHOR Olsen, Kenneth R.
TITLE Obtaining Related Services through Local Interagency Collaboration.
INSTITUTION Mid-South Regional Resource Center, Lexington, Ky.
SPONS AGENCY Office of Special Education and Rehabilitative Services (ED), Washington, DC.
PUB DATE [83]
CONTRACT 300-80-0722
NOTE 58p.
PUB TYPE Reports - Descriptive (141)

EDRS PRICE MF01/PC03 Plus Postage.
DESCRIPTORS *Agency Cooperation; Agency Role; *Cooperative Planning; *Coordination; *Disabilities; Educational Cooperation; Elementary Secondary Education; Financial Policy; *Shared Services

ABSTRACT

Designed as a resource for local school administrators, the report describes the experiences of 15 local special education agencies in providing related services at reasonable cost through interagency cooperation. An introductory chapter discusses the role of interagency committees (both policy and direct service types), and provides information on five local education agencies (LEA sites) with successful interagency networks. The importance of clarifying roles and responsibilities regarding needs and standards, resource allocations, and procedures is emphasized, and the example of one LEA's interagency agreement is offered. Joint funding considerations are analyzed and examples of five sites' approaches are given. Four site descriptions illustrate methods for pooling resources. A concluding chapter reviews potential problems in the interdisciplinary approach and ways to solve them. Each of the descriptions of model sites includes information on development and results as well as the name and address of a contact person. (CL)

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OBTAINING RELATED SERVICES THROUGH

LOCAL INTERAGENCY COLLABORATION

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OBTAINING RELATED SERVICES THROUGH LOCAL INTERAGENCY COLLABORATION

Kenneth R. Olsen, D.Ed.
Mid-South Regional Resource Center
University of Kentucky
Lexington, Kentucky

The Regional Resource Center (RRC) program is funded through the U.S. Education Department, Office of Special Education and Rehabilitative Services, Special Education Programs, to provide technical assistance to state education agencies through them to local education agencies. In addition to direct technical assistance, the RRCs are responsible for maintaining a specific type of information on successful practices in implementing PL 94-142. From 1980-1983 the Mid-South RRC at the University of Kentucky has served the states of Kentucky, North Carolina, South Carolina, and Tennessee.

This document was prepared as a part of a program assistance agreement with the South Carolina Office of Programs for the Handicapped under Contract Number OEC-300-80-0722 with the Office of Special Education and Rehabilitative Services, U. S. Department of Education. However, no official endorsement of the opinions expressed herein should be inferred on the part of the South Carolina Office of Programs for the Handicapped or the U. S. Office of Special Education and Rehabilitative Services.

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In the fall of 1980, Dr. Robert Black, Director of the Office of Programs for the Handicapped in South Carolina, requested RRC resources to be focused on a single, high-priority issue. Dr. Black's concern was that state interagency agreements were not being effective in getting related services to school children with handicaps. School districts were expending significant portions of their budgets on services that, with appropriate interpretations, could be the responsibility of agencies other than the schools. He believed that co-ordinated service efforts could result in lower costs to schools and higher quality, more comprehensive services to children. Dr. Black asked the Regional Resource Center (RRC) staff to conduct a national search for local education agencies that had found ways to obtain related services at low or no cost. This document represents nearly a three-year effort in that regard. The vision of Dr. Black in focusing on this issue is gratefully recognized.

The report that follows was possible only through the willingness of local school administrators to complete forms, answer questions, arrange schedules, provide written material, and review our drafts. The author is personally grateful for all the time they devoted to help their colleagues. State level personnel also gave a great deal of time for these activities; they were critical links throughout the study. Appreciation is also expressed to the members of the RRC network who freely shared site-visit materials. Special thanks go to the Mid-Atlantic RRC of George Washington University for allowing us to use their reports from Virginia Beach and from Salina, Kansas.

Without the contributions of the staff of the Center for the Study of Social Policy, this report could have become just another fragmented, redundant effort. Instead, the collaboration of Frank Farrow, Sally Diamond, Cheryl Rogers, and Tom Joe insured mutual benefit as we conducted parallel activities. Their contributions are too numerous to detail here (see the Appendix for a description of collaborative procedures).

Finally, contributing staff at the University of Kentucky must be recognized. The work of Ethel Bright of the Mid-South RRC was a significant factor in conducting and documenting site visits and in reviewing this report; and the careful editing by Carol O'Reilly is acknowledged and appreciated. Prodding encouragement of our director, Bob Sterrett, is also recognized as being crucial to completion of the task.

Even with all the expert help acknowledged, no doubt there are still errors in this report for which the author must take full responsibility. However, we trust that the information contained herein will not only meet the needs of South Carolina but of other states as well.

Kenneth R. Olsen

CHAPTER I
INTRODUCTION

"I will not follow where the path may lead; but I will go where there is no path, and I will leave a trail."

Muriel Strode

When the regulations for PL 94-142 went into effect in 1977, local education agencies (LEAs), as well as state education agencies (SEAs), began having similar problems with related services:

- Inconsistency in interpretation of related service mandates across states
- Confusion regarding the definition of related services:
  - When is service "related" rather than educational?
  - What criteria should be applied when related services are needed?
- Specification of related services in individual educational plans (IEPs) only to the extent that the service is available--not to the extent it is needed
- Difficulty in obtaining staff trained to provide related services in educational settings
- Withdrawal of related services by non-education agencies who assume education has the mandate to provide services, with agency dollars then being applied to other priority areas
- Lack of co-ordination and communication that results in duplication of efforts among agencies
- Mandatory provision by SEAs of related services that they cannot afford, but that the SEAs cannot require other agencies to provide
- Reduction of education dollars, but an increasing number of available dollars going to purchase related-service staff in LEAs
- The decrease of dollars going to education in general, but an increase in special education and related services that has resulted in a backlash on the part of the public reacting to what appear to be exorbitant expenditures
- The expectations of some parents and professionals that emerging treatment models will be a panacea -- and the related increase in requests to LEAs for specific related services

As programs and services expanded through interpretations of PL 94-142, the problem for local special education administrators became increasingly one of insuring maximum impact with limited dollars.

Introduction

Purpose

This document is designed to provide a resource to local school administrators for answering the question "HOW DO WE GET SOMEONE OTHER THAN EDUCATION TO ACCEPT SOME FISCAL RESPONSIBILITY FOR RELATED SERVICES TO SCHOOL-AGED HANDICAPPED CHILDREN?"

What follows is not a cookbook for obtaining related services. This report describes the experiences of fifteen local special education administrators in providing related services, at a reasonable cost, through collaboration with other agencies. The reader must review the various case studies and the generalizations in light of his or her own situation. Every context is different.

The intent of this document is to stimulate LEA special education administrators to consider going beyond LEA resources to obtain related services. The results of the site visits reported herein indicate that the benefits go far beyond fiscal matters. Increases in the quality of education and related services have occurred for children who are served in LEAs where co-operative arrangements have developed among agencies.

Overview

Chapters Two through Five contain descriptions of ways LEAs have worked with other agencies to obtain related services. The fifteen practices are grouped in four somewhat arbitrary catagories as there is a great deal of overlap among them:

Chapter 2: Interagency Committees - five sites

Chapter 3: Role Clarification - one site

Chapter 4: Joint Funding - five sites

Chapter 5: Resource Pooling - four sites

Every chapter is introduced with a description of the specific strategy followed by considerations for replication and the actual site report(s). Each practice is described in terms of how it operates, how it was developed, and the results that have been obtained. Name, address, and telephone number of the key person(s) at the site are provided so that the reader may obtain more information as desired.

Chapter Six summarizes what has been learned from studying successful local strategies. The intent of this last chapter is to generalize the experiences of these successful LEAs into statements that may be applied by those who wish to establish co-operative relationships for related services.

CHAPTER 2
INTERAGENCY COMMITTEES

John Naisbitt (1983) predicts that participatory democracy and networking will increase in use in the next decade. He says that

> ...networks are people talking to each other, sharing ideas, information and resources...They are structured to transmit information in a way that is quicker...and more energy efficient than any other process we know [pp. 192-193].

This chapter explores a mechanism for networking among agencies serving children with handicaps--interagency committees.

Strategy Description

The primary function of interagency committees is to establish a common information base. Interagency committees at the local level appear to be of two types: policy and direct service. Most of the successful sites studied had both types.

Policy Level. Policy level committees are made up of administrative representatives of social service, health, judicial, and education agencies. These committees develop interagency agreements, establish general frameworks within which agencies will operate, and take the initiative in developing new interagency programs and facilities. Most commonly, policy committees are served by a rotating chairperson, with agenda items submitted by any participating agency. Agendas frequently involve presentations by representatives as the laws and regulations affecting their service areas change. Priority needs that affect more than one agency are discussed, and mutually acceptable solutions are defined. Agencies not involved in a particular situation often serve as intermediaries to facilitate policy revisions for other agencies.

Direct Service Level. The other type of interagency committee focuses on individual children who are being served by more than one agency and for whom problems and/or conflicts have arisen. Representation by agency is approximately the same as for the policy committee, but the child-centered committee usually involves participation by persons at middle management or practitioner levels. These committees function much like IEP teams. They review individual cases, discuss children's needs and families' needs, discuss alternatives, and develop plans of action to reduce problems for individual children. The successful committees we observed tracked individual children until problems were resolved, thus serving a case management function.

Child-centered committees appear to be especially successful with children who are under adjudication

and/or are involved with major social service issues. The committees appear to be an excellent way to explore community alternatives to residential placements, a positive outcome being the reduction in those placements.

Child-centered interagency committees provide a common information base on clients. When agencies met to discuss a case, they often found discrepancies in the kinds of information that had been provided to them regarding an individual client or family. Additionally, the experience of many administrators has been that the decisions of the committee often result in the provision of related services by agencies that might not otherwise have provided them. Team dynamics have an apparent effect on an individual agency's willingness to provide service to individual children.

Considerations for Replication

1. Start with a specific case or issue. Most successful practices started with individual cases, individual policy issues, or underdeveloped areas of service that were of common interest. It may be best to develop an interagency committee starting with a specific situation and involve only those agencies with mutual interest. As new cases or issues arise, other agencies may become involved.

2. Facilitate informal relationships. An essential element of the successful committees was informal relationships among committee members. The development process should provide for informal exchanges that allow representatives to become fully acquainted with other individuals and the individuals' agency: Socializing over coffee, having informal meals, or simply meeting in a variety of offices.

3. Clearly define a broad-based role. The role of the committee must be sufficiently flexible to ensure that items of interest to all agency representatives can be considered. If an agency feels it has only a tangential purpose in attending meetings, it will withdraw. Consequently, the committee role is most effective if it deals with issues in addition to those that effect persons with handicaps, and with individuals who are of concern to more than one agency. The purpose of the committee should be specifically stated, but broad, documented and shared with all members. As the committee matures, this documentation should be shared with new representatives for orientation purposes. It may be revised as committee functions change, with agency members retaining an open mind regarding their role. Note, committee roles regarding policy issues and specific cases are best kept separate, handling them through separate committees or at least separate meetings.

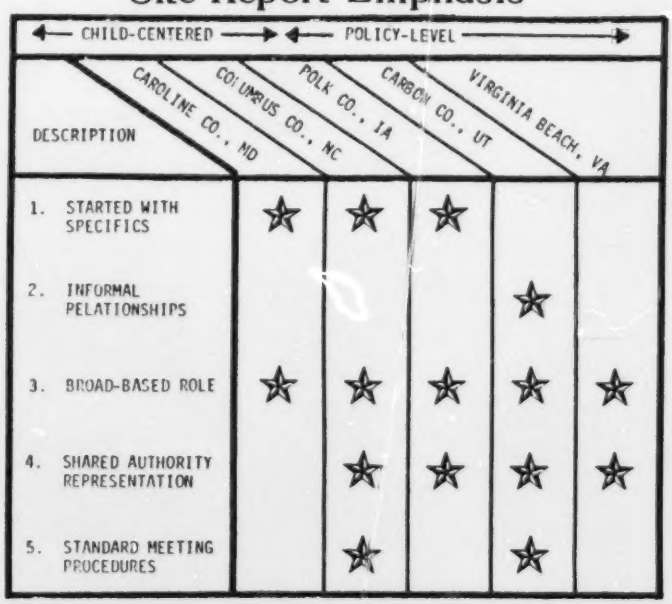
4. Share authority and ensure consistent representation. In order for agencies to feel equally vested, authority must not emanate from a single source. Chairmanship of the committee should rotate. Several of the sites visited recommended that middle managers are the most appropriate representatives on a child-level interagency committee. These individuals are aware of line functions, work closely with the administration, are open to change, and can cause change. It is, however, essential that there be consistent

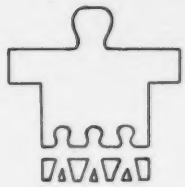
membership at whatever level is selected. The informal relationships that develop over the coffee pot cannot be maintained with inconsistent attendance. Additionally, top administrators within each agency need to sanction the committee and agree to devote staff time to committee activities. The committee must then accept its responsibility to define benefits for each agency and communicate them in support of the representatives.

5. Establish standard meeting procedures. Committee representatives submitted formal agenda items prior to the meeting in all but one of the committees we visited. At the child level, it is particularly helpful to have agendas consisting of individual cases divided into new cases, cases in process, and cases being tracked for follow-up. Using this technique insures that a child will not "fall through the cracks." Each meeting should be documented and minutes distributed. Such documentation confirms decisions made at the meeting; provides an accountability mechanism for those assigned to conduct follow-up and the impetus for necessary action; serves as an organizer for following meetings; and provides a stimulus for discussion of unresolved issues and cases. A summary also serves as a communication vehicle for individual representatives to discuss issues or cases with top-level management. Finally, documentation provides a permanent record of committee activity and serves as a reference tool if cases or issues re-emerge.

The five site reports that follow address the above issues. (See chart below.) These sites have successfully established interagency networks. Their co-operative efforts have increased related services to children without additional LEA financing.

Site Report Emphasis





CHILD-CENTERED INTERAGENCY COMMITTEE

Caroline County, Maryland

A child-centered interagency committee for handicapped and non-handicapped children referred by the agencies

DESCRIPTION: Caroline County is a small rural county in Maryland with one school district and an enrollment of 4,700 students. Individual representation from the following agencies forms the Caroline County interagency committee.

- Juvenile Service Worker: Department of Juvenile Services
- Chief Nurse for Mental Health: County Department of Health, County Department of Health and Mental Hygiene
- Nurse Practitioner: County Department of Health and Mental Hygiene
- Supervisor of Children's Services: County Department of Social Services
- Supervisor of Pupil Personnel: Caroline County School District
- Supervisor of Instruction: Caroline County School District
- Psychologist: Caroline County School District
- Counselor: Department of Vocational Rehabilitation
- Other Agency Representatives: as appropriate

Cases. Representatives meet twice a month for approximately two hours to share information on children of mutual concern; or for whom an agency is having difficulty developing a program and there is a desire for additional advice and input. Frequently children referred to the committee have a handicap; however, the committee also deals with non-handicapped students such as truants or delinquent children.

Meeting procedures. At each committee meeting, every member is asked if there are any children he or she would like to discuss. What usually ensues is discussion of from three to six children. Because the county has a relatively small number of students, the committee members often know the students in question. Many of these children have been seen by multiple agencies; so pertinent information is shared among committee members. After a discussion of the presenting problem, the committee members discuss alternative solutions, which usually involve several agencies. No policy-level decisions are made, nor agency matters discussed. Instead, the agenda focuses on problem solving for individual children. After a discussion of the problem, committee members take responsibility for follow-up tasks (e.g., arrangements

for medical examinations, home visits, or evaluations for individual children are accepted as the responsibility of individual agencies). Members report on their findings at the next committee meeting.

DEVELOPMENT: The committee was established in 1972 when District Judges ordered the Department of Juvenile Services to chair an interagency committee. The purpose of the committee was to assist the judges in their decisions concerning service plans for court-referred juveniles. Often, the judges would refer cases to this committee before they came to a court hearing. Two years after its inception, the committee decided to broaden its scope to include children who were at risk of becoming juvenile delinquents. Prevention thus became an important goal. Soon, the committee began to encompass all children with problems that might involve multiple agencies: handicapped children, non-handicapped children, and juvenile offenders.

RESULTS:

Service Delivery. The Caroline County Interagency Committee has been successful in reducing the number of placements made in non-public schools by county agencies. The committee has also served as a mechanism that allowed sufficient communication among agencies to preclude out-of-district placements. The interagency committee has prevented duplication of services through the sharing of information regarding services being provided to individual children and services planned. Services that are planned, but that might be redundant, may be eliminated at that time. In addition, the committee has been able to resolve communication difficulties.

Interaction. The committee has been successful in preparing agencies for future actions. In some cases future actions that would have been taken by individual agencies (e.g., court proceedings) were discussed at a committee meeting prior to the action in order that the agencies might be better prepared. The interactive effects of professionals looking at a particular problem from many different viewpoints has resulted in what the committee considers to be higher quality solutions than those that would have been reached by an individual agency. Consideration of a problem from a social service or health standpoint, as well as an educational standpoint, has resulted in greater benefit to the child and ultimately to Caroline County. Finally, the committee feels that interaction at committee meetings has an added benefit in that members of the committee can call each other for support when internal matters arise. On one occasion committee members agreed to write a letter to the Director of Mental Health urging him to hire a family therapist after they had heard from the Mental Health Nurse that it was being considered. They all had agreed that the position was needed, and they used their own agencies to support the move.

CONTACT:

Dr. P. Donald Parks
Supervisor of Instruction
Caroline County Board of Education
Denton, MD 21629
Phone: 301/479-1460

DEVELOPMENTAL DISABILITIES COUNCIL

A rural "Developmental Disabilities Council" that has written guidelines and formal meeting procedures

DESCRIPTION: Columbus County is a rural area (20 people per square mile) with a high percentage of migrants and a 3 1/2 percent native American population.

Purpose/Membership. The Columbus County Council on Developmental Disabilities meets monthly to review individual cases and to promote individualized planning and program co-ordination for persons with developmental disabilities. Member agencies include the following:

1. Columbus County Schools (school population of 8800)

2. Whiteville City Schools (school population of 2800)

3. Columbus County Mental Health Center

4. Columbus County Public Health Department

5. Columbus County Department of Social Services

6. Columbus County Workshop

7. SENCland Community Action, Inc.

8. Whiteville Vocational Rehabilitation Office

9. Juvenile Court Counselors

10. Development Evaluation Center, Wilmington

11. O'Berry Center, Goldsboro (State Regional MR Institution)

12. "Willie M" zone representative

Membership. Each member agency designates a permanent representative to the council. Guidelines indicate that the representative should hold a supervisory position and should be able to regularly attend meetings. Each representative may designate resource persons who can assist in developing programs. Those persons may be liaisons between the community and various treatment and special care facilities that serve Columbus County. Council guidelines specify procedures for selection, term of office, and duties for three council positions: chairman, vice-chairman, and secretary.

Agenda. The Council uses a standard agenda. During each meeting the members review minutes of the last meeting and report on pending cases. New cases are then introduced by the lead or referring agency. The Council then makes recommendations about the next steps to be taken. The number of cases per agenda ranges from five to

ten. Some cases remain on the agenda for several months; some are removed from the agenda but are again placed on it because of new problems. Current practice is to use the last part of each meeting to set the next agenda. Council members have learned that they are sometimes able to resolve problems by screening or merely introducing a referral, and the case need not appear on the next month's agenda.

Cases. The Council focuses on referred cases rather than systematic issues. Accepted for systemic individual referrals that meet the federal definition for developmental disability and have been identified or are being served by a member agency. Case referrals are screened and appear on the agenda when: each agency has exhausted its procedures, an agency knows that other agencies are involved but is unable to efficiently coordinate the services, or a very young child with special needs has been identified. The referring agency must have determined that the person needs more services than the agency can provide and could benefit from jointly developed comprehensive planning. The definition for eligible cases also includes any person being considered for admission to or release from a treatment or special-care facility that serves residents of the County, and "Willie M" cases (behavior disordered/disruptive).

DEVELOPMENT: Multi-agency planning began in 1974 in response to the local community college's effort to develop a sheltered workshop for de-institutionalized persons. After initial agency contacts, a specific council structure emerged in 1977 at the request of a school psychologist who sought a case review. The participating agencies had no guidelines for operation during the early stages. The group had previously reviewed and rejected a state agency request for proposals to operate a case management model program because they saw it as restrictive to their purpose. In November 1977 the group developed and adopted their own guidelines and has since revised them as necessary.

RESULTS: The Council has been effective in limiting the number of out-of-district placements by reviewing each case in terms of local agency alternatives. Families with histories of retardation/disabilities are carefully tracked to prepare agencies as children leave home and enter service systems. The Council has assisted member agencies in intra-agency problem solving and in supporting new program development. In at least one case, the Council has pressured a member agency into providing needed services; this agency recognized that the Council served as a safe forum for them to test the limits of their mandate. LEAs have reported that the Council saved them time in regard to contacting and negotiating with each agency separately. Agencies unanimously reported that clients received higher quality service as a result of Council interactions.

CONTACT:

W. Paul Pope III
Director for Exceptional Children
Columbus County Schools
P.O. Box 729
Whiteville, NC 28472
Phone: 919/642-5168

CO-ORDINATING COUNCILS

Carbon County, Utah

A "Co-ordinating Council" that has effected systemic change and distributed costs equitably

DESCRIPTION: Carbon County is a rural area in southeastern Utah with a single school district that serves 5,200 students of which approximately 450 have handicaps.

Representation. The "Co-ordinating Council" of Carbon County consists of two separate bodies, each holding meetings once a month. Both groups are comprised of representatives from the following public and private agencies:

- School District
- Community Mental Health Center
- Alcohol and Drug Abuse Division
- Division of Family Services
- Human Services Department
- Vocational Rehabilitation
- Juvenile Courts
- Employment and Training Department
- Public Health Department
- Planned Parenthood Agency
- Sheriff and Parole Board

One body consists of the Directors of each of the above agencies, with the school district represented by the Director of Special Education. This body makes broad policy decisions. The second is a larger body and consists of staff persons from each agency. Typically, school psychologists and principals represent the school district, nurses represent the Department of Public Health, counselors represent Vocational Rehabilitation, Psyciatrists represent the Division of Mental Health, and so forth. Except for the school district, whose jurisdiction covers only Carbon County, each of the other agencies represented on the co-ordinating council covers a three-county area conforming to a district planning area.

Structures. The structure of the committees includes a Chairman elected annually from among member agencies. All members are invited to submit agenda items for discussion at the monthly meetings. Sub-committees are established to deal with particular problems or activities as they arise. The co-ordinating committees address interagency problems that concern children -- both handicapped and non-handicapped.

Agency Directors Council. Policy related to children with handicaps has

been a priority of the Directors Council because of their perception that effective comprehensive services require participation by many of the member agencies. Much of the council's efforts have involved attempts to expand services and access to services. They work to use minimal funding to provide maximum services through a variety of sources. As an issue is discussed at the Director's meeting, a solution is decided upon; and individual members or task forces are assigned responsibility for follow through. It may take the form of testifying about needs for new programs, developing proposals, or conducting joint needs assessment. All conflicts are handled on an administrative basis, and in many cases agencies help each other out of conflict within their own systems.

DEVELOPMENT: In 1976 the Carbon County School District was involved in a pilot direction-service project funded by the Federal Government. This project required interagency collaboration to ensure comprehensive information and referral services for individuals with handicaps. As a part of this project, an Advisory Committee was formed consisting of the previously listed agencies. They realized the need for a committee to co-ordinate activities involving multiple agencies and to develop new interagency projects to address unmet needs. Agency directors recognized a local need to co-ordinate activities on behalf of handicapped children. The committee was formed and has met regularly since that time. Relationships among agencies have been maintained through both formal and informal means. Agency directors go out of their way to maintain informal contacts between meeting dates.

RESULTS: The Co-ordinating Council has established a preschool program, where none had previously existed, and a sheltered workshop for adolescents, and succeeded in getting one of its members appointed to a statewide policy committee. It has obtained additional staff for individual agencies through pressure from other administrators within that agency. The council has supported each member agency in developing proposals. By speaking with a single voice, the agencies are able to command attention and obtain more than a proportionate share of service resources. Agency representatives feel that the likelihood of appropriately meeting multiple needs of children with handicaps is much greater as a result of the council's co-ordinated functions. Agency directors believe that budget savings have resulted from council actions because of reduced duplication of services. The council provides a forum for resolution of conflicts that also has proved extremely important. In some cases costs have been allocated more efficiently among agencies. As the program development indicated, availability of services to children with handicaps has been increased and broadened. Finally, participants note that the speed with which services are delivered has increased and red tape has been minimized.

CONTACT:

Dr. Robert Hansen
Carbon County School District
Price, UT 84501
Phone: 801/637-1732

INTERAGENCY SCREENING COMMITTEE

Polk County, Iowa

An "Interagency Screening Committee" developed to establish working relationships among agencies

DESCRIPTION: Polk County is located in the center of Iowa, Des Moines being the major city. The Des Moines Public Schools serve a total school population of 30,915 students, with another 20,250 in the county.

Representation. On a monthly basis the interagency screening committee meets with representatives (supervisory staff) from the following:

- Area Education Agency (Social Worker)
- Des Moines Public Schools (Co-ordinator for Programs for the Emotionally Disturbed and Social Work Co-ordinator)
- Polk County Juvenile Court (Probation Supervisor)
- Polk County Department of Human Services (Foster Care and Mental Health Units)
- District Department of Human Services (Section of Youth Services)

Issues. Ninety-five percent of the issues within the program deal with children who have emotional disturbances or children who are chronically distruptive. The majority of issues deal with systemic problems, those that occur when one agency is having a problem with another agency. Individual cases are "staffed"; however, the committee usually deals with particular classes of cases. Many of the cases involve children who are to be placed outside of the Des Moines area and will be adjudicated or involved in intensive long-term care.

Procedures. Each agency representative brings a list of problems to discuss and asks for advice or reaction from the committee. Sometimes a meeting is used to conduct training in regard to changes in agency laws or regulations. There is never a formal agenda, but individual members are usually aware of the topics to be discussed. Agencies other than those already involved will sometimes use the meetings to try out case issues [e.g., How should a case of this type (name will be deleted) be handled by our agency?]. Resolution of all issues is documented and shared among agencies.

DEVELOPMENT: The interagency committee was established in February 1978 as a result of communication problems. In the years prior to PL 94-142, the juvenile court and the Department of Human Services had placed children in out-of-state institutions without considering educational needs. After PL 94-142 it

was expected that local school districts pay for educational services for these children. But local schools and the area education agency questioned these placements and the cost of the program. There was a need to determine who was to make the decisions about children placed by Human Services. A general feeling arose that education had been excluding children from services and that the concept of PL 94-142 was overwhelming and confusing. Agencies did not know each other's rules and regulations, and believed that there was a great deal of miscommunication among themselves.

Formal Agreement. These problems led to a formal agreement between the district administrator for the Department of Human Services and the Director of Special Education of the Area Education Agency (Intermediate Unit) regarding placement procedures. The agreement called for a meeting of the agencies when a placement was being considered. The Juvenile Court Supervisors were invited to attend because of the nature of the cases to be discussed. Originally the agenda was limited to specific children but has since moved to policy issues with individual case staffings as a lower priority item. A key element in the development has been the involvement of the school social worker who represents the Area Education Agency as a liaison and serves as a link with the participating agencies. She is often used to present sensitive cases since she is considered a person with low ego involvement and with concern only for problem resolution.

RESULTS:

Children Better Served. The interagency screening committee has been able to return several children to Polk County who had been placed out-of-district. Prior to installation of the committee, children placed out-of-district would return; but communication regarding why they left or the circumstances of their return would be lost. Perhaps the most significant outcome is that these children are no longer lost between agencies as the interagency screening committee maintains awareness of all children placed out- of-district.

Information Flow. Participants feel that the screening committee saves time and increases the flow of information. There is no loss of information through secondary sources. Each agency has begun to learn more about the limitations and flexibility of the other and can often suggest solutions within an agency's mandates. Additionally, agencies feel they can co-operate to provide professional pressure on those not providing adequate services.

Conflict Resolution. Having first-hand information regarding other agencies leads to better understanding. The interagency screening committee eliminates the adversarial role and establishes an atmosphere of open and honest discussion. The council may then serve as a mechanism for informal mediation.

CONTACT:

Ms. JoAnn Neal
Senior School Social Worker
Area Education Agency 11
1932 Southwest Third Street
Ankeny, IA 50021
Phone: 515/964-2550

FOCUS TEAMS

Virginia Beach, Virginia

Two interagency problem-solving teams in the Virginia Beach area.
"Focus Team I": Clients of the Virginia Beach Department of Mental Health/Mental Retardation (MH/MR)
"Focus Team II": Clients of other area human service agencies

DESCRIPTION:

"Focus Team I"

Roles, Cases, and Issues. Focus Team I is responsible for specific case needs of clients with MH/MR and for policy issues related to the integration of human services. The team plans for a client's entry to or release from residential placement. It also deals with clients for whom all resources have been exhausted, clients who are falling through the cracks of the service structure, or clients for whom MH/MR services would be enhanced by complimentary services from another agency.

Representation. Focus Team I has a core membership of representatives from MH and MR services, social services, health departments, public schools, and rehabilitation services. Membership varies depending on the disability of the client, but may include representatives from the Southeastern Virginia Training Center, Comprehensive Mental Health Services, Tidewater Association for Retarded Citizens, Virginia Beach Parks and Recreation, Volunteers of America, Tidewater Child Development Clinic, Eastern State Hospital, Volunteers of America, and Tidewater Psychiatric Institute.

Procedures. The team meets monthly but convenes more often if needed. Each of the three main programs operated by the department of MH/MR -- Mental Health, Mental Retardation/ Developmental Disabilities, and Substance Abuse -- has designated one staff member to co-ordinate focus team reviews in their disability area. Team co-ordinators jointly schedule case reviews; ensure all required documentation is available; and notify families, clients, and agencies. Minutes are kept of all meetings. Required records are maintained by each Focus Team Co-ordinator for cases in their disability area. They are also responsible for taking all required follow-up actions to implement focus team recommendations including contact with the client/ family. All clients whose cases are reviewed by the Focus Team receive case management services from staff in the appropriate program.

"Focus Team II"

Roles and Representation. Focus Team II handles cases that are beyond an agency's resources or cases that can't be handled by existing arrangements or programs. The membership of the team includes representatives from Special Education, MH/MR Social Services, The Department of Corrections, Division of

Court Services (Probation), and the Pendleton Child Service Center (a public, no-cost service provider for children with behavioral disorders).

Procedures. Focus Team II agendas deal with specific cases on an as-needed basis and are less formal than Focus Team I. Although it is often viewed as a "special education focus team," meetings are called by any agency represented. An appropriate case worker accompanies each agency representative. Service recommendations, however, are not necessarily binding on a responsible agency. Focus Team II occasionally meets to prepare the community to receive a problematic client from an institution.

DEVELOPMENT: In 1968 Virginia legislated the establishment of community services boards so that MH/MR patients could be de-institutionalized. A later amendment established the "prescription team" to integrate the community services necessary to accomplish effective pre-screening and pre-discharge planning.

Expansion of Existing Committee. Virginia Beach expanded on its already existing interagency focus team to meet this mandate. The original Focus Team I was established by the initiative of the Virginia Beach Community Services Board, an administrative board appointed by the City Council and responsible for the provisions of MH/MR programs in the community. Focus Team II was initiated by special education administration who contacted the Office of the City Manager. A second Focus Team was suggested as a mechanism for other human service agencies to handle cases similar to those coming before Focus Team I. The City Manager strongly supported the proposition and facilitated participation of representatives from each agency.

RESULTS:

For Clients. The teams are responsible for retention of clients in family and community settings rather than residential placements. A number of cases that had previously presented problems are now receiving responsive and appropriate services.

For Agencies. Expenditures for residential placement have been reduced. Focus Teams are seen as beneficial mechanisms for sharing information about specific agency resources and limitations as well as administrative procedures and functions. Each agency representative feels more informed regarding the availabilty of community services for clients. Focus Team meetings have pinpointed service gaps and overlaps when multiple agencies serve clients. Mutual sharing has built trust that has led to extensive collaboration on other issues. A strong sense of community has developed.

CONTACT:

Mr. Howard Cullum, Executive Dir.
Virginia Beach Community Service Bd.
Pembrook Office Park
Pembrook 6, Suite 218
Virginia Beach, VA 23462
Phone: 804/499-3737
OR
Dr. Thomas Curran, Director
Department of Special Education
Virginia Beach Public Schools
Virginia Beach, VA 23462
Phone: 804/427-4778

CHAPTER 3
ROLE CLARIFICATION

The Regional Resource Center program has defined interagency collaboration as a process that --

> Encourages and facilitates an open and honest exchange of ideas, plans, approaches, and resources across disciplines, programs, and agencies...enables all participants jointly to define their separate interests, and mutually identify needed changes in order to best achieve common purposes; and utilizes formal procedures to help clarify issues, define problems, and make decisions.
>
> (RRC Task Force, 1979)

The results of such decision processes are frequently interagency agreements that clarify roles. Many writers have described interagency agreements (McLaughlin and Christenson, 1980; Magrab and Elder, 1979; Osteen and Prover, 1980; Ferrini, et. al. 1980; Phelps, 1981; Martinson, 1982; Johnson, McLaughlin, and Christenson, 1982; Baxter, 1982; RRC Task Force on Interagency Collaboration, 1979; Mid-Atlantic RRC, 1982a, 1982b; Center for the Study of Social Policy, 1983). This chapter is therefore devoted to a synthesis of previous work, with only one site report provided as an example.

Strategy Description

Typically, one or more of the following agencies become involved in the development of interagency agreements: education, rehabilitation, crippled children's services, social services, mental health/retardation, and corrections. Most frequently, agreements involve a specification of relationships between two agencies in one or more of the these areas:

1. Needs and Standards. Interagency agreements are sometimes necessary to interpret federal and state initiatives at the local level. They can be used to identify duplicated services and to reduce and eliminate them. Agreements may specify the qualifications of personnel, characteristics of facilities and equipment, or expected outcomes. Detailed agreements of this type are contracts; however, more general agreements may take the form of "memoranda of understanding." The latter sometimes specify a procedure for monitoring or evaluating the specified standards. A third and final type of agreement may simply define terms and specify the difference between "education" and "related services".

2. Resource Allocations. Interagency agreements are especially useful in defining resource allocation. Audette (1980) listed six resource allocation plans that might be presented in such an agreement.

(1) First-Dollar Agreements --

specify which agency pays first and under what conditions the other agency will pay.

(2) Complimentary Dollar Agreements -- specify the specific services for which each agency will pay.

(3) Complimentary Personnel/ Dollar Agreements -- specify how one agency will allocate personnel for certain services while another agency will reserve funds to pay for other services.

(4) Shared Personnel Agreements -- specify how staff of two agencies will work together, usually on issues of common interest, but sometimes on trade offs.

(5) Shared Facility Agreements -- specify how an agency may use another agency's facility usually because of ease of access or unique characteristics.

(6) Shared Equipment and Materials Agreements -- specify under what conditions an agency's unique or easily available equipment and materials may be used by another agency.

3. Procedures. Agreements may be used to specify procedures. Descriptions of how children move from school to non-school services (and from non-school services back to school services) insure that children will not fall through the cracks if related services are provided through other than LEAs. Agreements may specify or indicate --

- 0 Child Identification: Co-operative "case-finding" efforts, joint screening procedures, and consistent referral procedures
- 0 Diagnosis and Evaluation: The sequence of events leading to and the types of information emanating from diagnostic procedures conducted by another agency
- 0 Planning and Placement: How each agency is notified of and involved in decision-making about individualized planning for each child
- 0 Delivery: Communication protocols, procedures for service provision, and how services are to be delivered
- 0 Re-evaluation/Plan Revision: How each agency has the option to call for a meeting to revise a plan and the procedures to be followed in conducting re-evaluations

Procedural agreements are also helpful in defining co-operative support operations by specifying procedures for --

- 0 Child Tracking and Information Sharing: Using a shared data base and the extent to which information will be shared among agencies
- 0 Information and Referral: Access to another agency's information sources (e.g., a computerized service directory)
- 0 Training: Co-operative staff training procedures to determine how common needs will be identified and how training will be provided and evaluated

Considerations for Replication

1. Establish a shared awareness of need. Co-operative planning will not occur until particpating agencies agree they have a problem and are not simply working on your problem. Some LEAs have found that parents are effective communicators of need and have asked them to quietly inquire of agency heads and, if necessary, city/county council representatives

regarding disjointed or inaccessible services. (This strategy also works in reverse!)

2. Communicate turf gripes. Conflict should not be avoided; its resolution will lead to a stronger agreement. Each agency brings perceptions about how services should be provided and who should have authority. An early agenda item should involve informal sharing about perceptions and personal needs.

3. Learn the language. Much unnecessary conflict results from lack of understanding about mandates, authority, funding mechanisms, referral and supervision requirements, and employee/employer relationships in other agencies. Human service agency personnel are afraid they'll never understand the complexities of PL 94-142, why all children have to be served, and the range of "educational" placements. Educators have difficulty with third-party payments, setting what appear to be arbitrary cut-offs for services, and the need for some service agencies to be self-supporting. Terms with special meanings to one agency or discipline also cause misunderstandings as they may be general terms to other agencies. Agreement planners must learn to question each other about terms and must set aside time to learn how the other agencies function.

4. Analyze mandates and latitude. State agreements that specify detailed relationships at the local level have not proven to be very effective. On the other hand, local agencies operating in states where state-level agencies have "agreed to agree" have been allowed the latitude to develop agreements that address local needs. Such local agencies have perceived general support from the state level for co-operative effort. Local agencies interested in developing co-operative agreements may need to ensure that their state level counterparts support their efforts. This can be accomplished through a joint letter, to both agencies, requesting interpretation of roles and flexibility. Administrative authority for co-operation must also be obtained.

5. Consider involving a facilitator. Experienced outside facilitators are effective in reducing turf issues, in asking questions that need to be asked, and in leading agencies through necessary decision processes. Although not essential, the facilitator can serve as a buffer for the agencies. Concerns can be posed to this impartial individual whose only interest is problem resolution. A skilled facilitator will understand the steps through which the group must proceed and ensure that progress is neither too slow nor too fast. Finally, the facilitator will have responsibility to document results and to co-ordinate communication. More information on involving outside facilitators is available in The Interdependent Community: Collaborative Planning for Handicapped Youth by Paul Ferrini, Bradford Mathews, June Foster, and Jean Workman, May 1980. (Available from Technical Education Research Centers, 44 Brattle Street, Cambridge, MA 02138).

6. Clarify content of agreement. There appears to be several essential components of successful interagency agreements.

- Statement of Purpose - A clear statement of the expected outcomes

of the agreement

- Definition of Terms - A list of terms defined in unambiguous language
- Program Needs and Standards - Why is it needed, and what will it do?
- Resource Allocations -
  1. Dollars - Who pays and under what conditions?
  2. Staff - How and under what conditions will staff be available?
- Procedures and Responsibilities - What must happen, for example, with child services, confidential information, and support operations? How and when will services start and end? Who is responsible?
- Agreement Administration - How and when will the agreement be administered, monitored, evaluated, and updated? Who will be involved? Who has responsibility for each step? How will information be communicated? What sanction will be employed if goals are not met?

7. Plan comprehensively. The RRC Task Force on interagency collaboration described a detailed procedure for developing an agreement in Interagency Collaboration on Full Services for Handicapped Children and Youth: A Guide to Local Implementation, 1979, RRC Program of DE/OSERS.

Strategy 1.0 Determine needs and rationale for initiation of interprogram collaboration project.

Task 1.1..Conduct needs assessment.

Task 1.2 Prepare a statement of proposed goals, objectives, procedures, timelines, responsibilities, and expected outcomes for recommended interagency collaboration.

Strategy 2.0 Define service-delivery populations of interest.

Task 2.1 Develop a conceptual framework for defining the service populations (e.g., age levels, types, or severity of handicap).

Task 2.2 Identify the population(s) that are most problematic for delivery of full services.

Strategy 3.0 Identify agencies and programs serving or authorized to serve the target population(s) and contact agency administrator.

Task 3.1 Review state-level agreements, state program/service directories, and relevant state statutes to determine which state agencies/programs currently provide services to the target population(s).

Task 3.2 Contact agency(ies') representatives.

Task 3.3 Meet with agency(ies') representatives to establish mutual needs and goals for collaboration.

Strategy 4.0 Define current program policies and service responsibilities of identified programs.

Task 4.1 Review state-level interagency agreements and the needs/goals established in Strategy 3.0.

Task 4.2 Analyze local program policies and procedures in order to list responsibilities, resources, and current practices.

Strategy 5.0 Compare local programs and procedures to identify gaps, overlaps, constraints, and needed linkages.

Task 5.1 Compare the data collected in Strategy 4.0 across agencies with needs established in Strategies 1.0 and revised in 3.0. Identify met and unmet needs.

Task 5.2 Compare the data collected in Strategy 4.0 across agencies with state-level agree-

ments. Identify areas of compliance and noncompliance.

Strategy 6.0 Identify local policies and procedures wherein modifications would enable satisfaction of need and rationale for collaboration, and specify the needed modifications.

Task 6.1 Using the gaps, overlaps, constraints, and needed linkages identified in Strategy 5.0, outline modifications that would solve or remedy these problem areas.

Strategy 7.0 Determine which modifications can be made on the local level, and incorporate them in a local interprogram agreement.

Task 7.1 Determine type of agreement -- policy and/or operational.

Task 7.2 Outline modifications to be included in the agreement.

Task 7.3 Circulate draft among affected staff for final input.

Task 7.4 Prepare final interprogram agreement and submit for appropriate signatures.

Strategy 8.0 Enable implementation of interprogram agreement.

Task 8.1 Design and execute a dissemination system to make appropriate personnel, parents, and the community aware of the new interprogram agreement.

Task 8.2 Design and execute a joint inservice training program for appropriate personnel.

Strategy 9.0 Implement local evaluation functions.

Task 9.1 Solicit feedback from personnel, students, and their parents as to whether or not the needs identified in 1.0 are being met (Summative Evaluation).

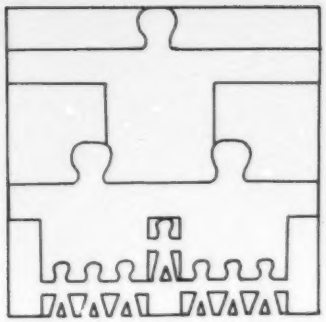
Task 9.2 Collect input from staff in an ongoing manner and analyze as to problems occurring in implementation of the written agreement.

Task 9.3 Make revisions to the agreement as indicated by information received in 9.1 and 9.2, following procedural format in 5.0-7.0.

8. Dispel fears through careful transition. The Mid-Atlantic RRC studied a variety of agency relationships. They concluded that successful, long-term relationships are established when agency personnel take time "to plan for a transitional phase that bridges the old way of operating and the new." This transition reduced fears of change and feelings of threat.

- Create small committees to set the stage for transition.
- Pace the changes to allow for adjustment.
- Make the first changes in areas of immediate need where benefits will be most evident.
- Integrate services instead of replacing services previously provided by an agency.
- Permit agencies to "try on" the agreement, eliminating surprises.
- Enlist the help of the most charismatic, congenial person on the committee to convince those who resist collaboration.
- Customize a training and reinforcement process; use strategies and tasks that will minimize disinterest, apathy, and burnout.
- Use resolution techniques to reduce interpersonal conflict. 1982a,

The following site report demonstrates the success of three agencies in developing and implementing the interagency agreement process.



INTERAGENCY AGREEMENT

SPECIAL EDUCATION, VOCATIONAL EDUCATION, AND VOCATIONAL REHABILITATION

Upper Peninsula, Michigan

An agreement among Special Education, Vocational Education, and Vocational Rehabilitation: specifies services to be provided by each agency, clarifies eligibility criteria and fiscal responsibility, defines dispute resolution mechanisms, links directly to a state-level agreement among the participating agencies.

DESCRIPTION: Two intermediate school districts (ISDs) that serve the rural Upper Peninsula of Michigan -- the Marquette-Alger ISD, operating from Marquette, and the Delta-Schoolcraft ISD operating from Escanaba -- have entered into co-operative agreements involving special education, vocational education, and vocational rehabilitation. The intent of the agreements is to enhance co-ordination among the three agencies resulting in a smooth transition from a students' educational program to a students' vocational rehabilitation and eventual employment.

Population. The population served by the agreement consists of students who are eligible for special education programs, ready for the vocational education segment of their program, have a disability that consitutes a vocational handicap, and may be expected to achieve at least sheltered employment. The population does not include learning disabled children unless they are diagnosed as having neurological disfunction, organic brain syndrome, mental retardation, or mental illness; and if the condition results in limited vocational functioning.

Rehabilitation Services. The agreement calls for the district office of the Michigan Rehabilitation Services (located in Marquette, Michigan) to provide the following for special education students in school: medical examinations for eligibility; physical restoration services related to employability; employer costs related to student's work-study placement; funds for transportation, tools, supplies; evaluation and special equipment for driver education; vocational assessments; and consultation services.

Special Education Services. In the context of this agreement, special education provides: (1) personal adjustment training and pre-vocational education, (2) diagnostic assessment, (3) a one-year, post-school follow-up, (4) special education and related services as needed, (5) referral and linking service to vocational education and rehabilitation, and (6) assistance with instructional strategies to vocational education teachers.

Vocational Education Services. Vocational education may include the

following services as needed: regular and adapted vocational education training; recommendations to special education and rehabilitation regarding prerequisite skills for vocational education; and consultation and information regarding vocational education.

Process. Special education students age 16 and above who are eligible for rehabilitation services are referred to the Michigan Rehabilitation Services district office, which in turn assigns a counselor. The counselor insures that appropriate reports are available, participates in the vocational placement IEP meeting, and works with special education and vocational education to develop a specific and appropriate program for each student. Individualized vocational planning for youth not involved in vocational education is based upon a curriculum developed by the Marquette-Alger ISD.

Conflict Resolution. If disagreements arise in dealing with programmatic or service delivery issues that cannot be resolved for an individual case, three representatives discuss the case: the district supervisor for rehabilitation services, the intermediate school district special education director, and vocational education director. If agreement still cannot be reached, then a decision may be requested from the State Department of Education in accordance with a state-level interagency agreement.

DEVELOPMENT: General working relationships among special education, vocational education, and vocational rehabilitation were well established at the time a statewide agreement clarified the above roles. The state-level agreement was provided to the local agencies as a permissive model for co-operation. The state established a three-member task force of representatives from each agency to serve as a resource to local planning teams. The task force contacted the agencies in the Upper Peninsula and suggested that the agreement be developed. Because the three groups had worked through most of the turf problems, transition to the agreement was accomplished in just a few meetings.

RESULTS: The co-operative arrangement has been successful in increasing the employability of secondary students. Relationships between vocational education and special education have resulted in changes in the special education curriculum in order to better prepare students for vocational training. Early involvement of vocational rehabilitation in secondary programs, facilitated by both special and vocational education, has minimized service gaps and has increased the availability of devices to assist students in need.

CONTACT:

Mr. John Lindholm, Director
Special Education
Delta-Schoolcraft ISD
810 N. Lincoln Road
Escanaba, MI 49829
Phone: 906/786-9301
OR
Ms. June Schaeffer, Director
Special Education
Marquette-Alger ISD
427 W. College Avenue
Marquette, MI 49855
Phone: 906/228-9400

CHAPTER 4
JOINT FUNDING

> Effective co-ordination of... diverse agencies is difficult if not impossible, given existing organizational patterns and competing authorities. Organizations tend to give first priority to organizational survival and enhancement and second priority to solution of problems they were organized to solve. There is no profit in deploring this universal characteristic of organizations. In fact, without it, nothing might ever get done. The lesson to people concerned with exceptional children is to put the principle to work on behalf of exceptional children.
>
> Nickolas Hobbs, 1975

A number of LEAs have taken Hobbs' admonition to heart by negotiating local and additional state and federal funding, both public and private, for co-operative efforts. These agencies are thus parties to what Martinson (1982) has called "The Competition/ Co-operation Paradox Syndrome". He states that --

> History suggests that co-operation is basically 'co-ordinated competition'. Agencies will commonly co-operate to more effectively compete with other groups for programs and resources. This syndrome is particularly acute during fiscal austerity periods. (p. 392)

But LEAs can effectively use this "syndrome" to the advantage of children. Co-operation to compete for funding frequently leads to better understanding between co-operating agencies and eventually to better programming for children. This chapter describes the characteristics and benefits of such arrangements.

Strategy Description

Five sites are reported in this chapter. In each case the LEA and other local agencies promoted their relationships as an effective use of state and federal resources. Each proposed to contribute its unique skills, facilities, and materials while recognizing those same attributes in the other agency. Proposals described how the relationship would be effective for children, would maximize resources, and would serve as a model for other agencies. Funding usually came from a single agency, which in two cases was not the SEA. Agencies that have co-operated to obtain joint funding for programs within their community have demonstrated that such programs reduce tuition expenses; decrease the number of residential placements; increase access to transition services (movement from a local residential facility into the high school or transition from the community living alternative to an employment setting); and increase the opportunities for parents to be involved in programs. Two of the examples cited have

established summer programs through external funding and thus provided needed services without establishing a precedent for full-year programs. All sites were able to obtain funds to initiate their program and have since garnered local education, mental health, and vocational education support. In several cases, funding of education and mental health services has set a precedent for similar co-operative arrangements desired by state agencies.

Considerations for Replication

1. Define shared need. All co-operating agencies that developed a joint proposal, and subsequently had it funded, shared the perception that the particular need was "owned" by all of the agencies involved. Personal contacts with SEA personnel was initiated prior to developing any proposal. In one case the agencies requested and obtained funding for a needs assessment and feasibility study. This technique may be helpful to obtain not only initial funding for the needs assessment, but initial commitment on the part of state agencies. In all cases the executive director of mental health organizations and school superintendents were directly involved in and aware of all stages of development, support thus being obtained from the highest administrative level within each organization.

2. Organize as a business. Co-operatively developed programs must frequently depend on tuition income from other school districts and private service contracts in order to be cost feasible. Educators must spend time learning about reimbursement structures and necessary fiscal arrangements of their co-operating agency. Participants must think of these programs as a business, albeit (for the most part) a publicly supported business. Many regional MH/MR boards are privately operated and thus must see a financial future in ventures in which they engage. Since they have experience in marketing their services, in handling collections, and in dealing with high-cost individualized services, education agencies should not be afraid to allow them to be the fiscal agent for the contract. The gains in terms of broader geographic coverage, the business orientation, the ability to handle third-party payments, and the accepting attitude of the MH/MR boards regarding high-cost individualized services will usually more than compensate for any loss of authority by the education agency.

3. Establish mutual trust and respect. In order for co-operative funding arrangements to function effectively, staff of the respective agencies must establish interpersonal relationships conducive to co-operative endeavors. An essential first step in proposal development and program planning is for administrative and program staff to get to know each other personally. Most of the individuals involved in sites documented in this chapter had extensive one-to-one, face-to-face meetings prior to ever putting words on paper. They had to learn to trust each other: The staff of each agency felt that staff of the other agency a) were committed to quality services; b) could do better than persons from their agency in regard to some activities (i.e., the inter-disciplinary approach); c) cared about children and their needs; d) were willing to trade services; and e)

expected mutual benefits from co-operation. This attitude was evidenced in how agency staff focused on areas about which they agreed to collaborate and ignored those upon which they disagreed. An effective technique in ensuring that disputes did not arise was to maintain two levels of planning groups: Administrators focused on policy and administrative issues, and service-delivery level persons focused on program and specific delivery issues.

4. Establish a positive program image. Establishing a positive program image has two components. In the first place, it is essential that the jointly funded program have an identity in and of itself. Education, mental health, and vocational education staff must be considered employees of the program and not employees of one agency. Although fiscal arrangements are usually such that the persons are employed by one or the other agency, administrators can establish and maintain a program identity by referring to them as staff of the "blank" rather than our staff at "blank". The second component of a positive program identity is to make the program highly visible. Use of the media to describe initial funding and successes assists the executive director of the co-operating agency as well as the superintendent. Each developmental step should be made public: preliminary feasibility studies, initial receipt of funding, initial opening, and any subsequent developments. As the process continues, successful co-operating agencies have made sure that the state agencies also received some of the credit for the development of the program. Contacts with legislators and higher level state officials regarding the success of the program improves the disposition of the authorities in state agencies toward continued funding.

5. Involve the community. Successful operation of jointly funded projects requires that there be extensive local involvement. High visibility increases the likelihood of local individual involvement in the program. Use of advisory committees and frequent contact with parents, the town council, school board, MH/MR board, and other appropriate agencies, boards, and individuals increases community predisposition to program support. Because most jointly funded programs have an outreach component, it is equally important that the program is promoted in the "home" or "sending" school district/town as a community program. Involvement of regional personnel on boards increases the chances that the program will be perceived as their community program as well as yours.

In summary, jointly funded programs are most effective when the participating agencies are willing to relinquish some authority in return for the benefits that accrue to individual children and to the LEA in general. Confidence of LEA staff in the quality of services provided by other agencies; feeling that other agency staff are willing to provide similar trade offs; and promotion of the program as neither "yours", nor "mine", but "ours" is essential to success. The following five sites demonstrate this concept of joint ownership.

NEW DIRECTIONS

Independence, Missouri

A co-operative day program between the Independence, Missouri School District and Comprehensive Mental Health Services, Incorporated, of Independence (CMHS) designed to serve children with behavior disorders, who are between the ages of eight and fifteen years

DESCRIPTION:

Cases. Children residing in the Jackson County service area are eligible for referral to New Direction. Students must have a severe behavior problem and have been previously served in a school district special education program where the program failed to meet the child's need.

Procedures. When a child meets eligibility criteria, a standard IEP meeting ensues, with most services provided in a self-contained class with a teacher and an aide. Instruction is supported by daily sessions with a recreational therapist. Once a week each child sees a psychologist for individual and small group therapy, and the parents then meet with the psychologist. Occupational and speech and language therapy are available on a consultant basis.

Management. Curriculum consists of regular junior and senior high school materials. Ongoing contact with the school district ensures integration of programs. Behavior and classroom management are based on a point system for junior high students and a monetary system for senior high students. Suspension is used only as a last resort. Daily reports are prepared for parents, and informal conferences are held regularly among staff.

Resources. The LEA contributes approximately $70,000 in local money and CMHS (the fiscal agent) $120,000; $42,000 has been obtained from the SEA. A standard tuition fee is charged for all participating LEAs outside of Independence. Per diem costs are $28, with actual costs closer to $50 per day. Parents pay for services in the summer. (Consequently, there is no twelve-month school year precedent.)

DEVELOPMENT: The Independence LEA has had ongoing contact with CMHS through an interagency direction-service project and contracting for specific services. They agreed to consider the development of within-district services for pupils identified as having an emotional disturbance. The LEA approached the SEA to explore the use of PL 94-142 discretionary funds to hire an interagency co-ordinator to work toward service development. In August of 1979 an interagency grant was funded; and a consultant was obtained.

Joint Funding. After a feasibility

study was conducted, LEA and CMHS proposed joint funding by the state education and mental health agencies. The program was funded with a one-semester planning segment to precede implementation in January 1982. The original plan was to obtain equal funding from both state agencies ($25,000 each), but the Department of Mental Health was unable to provide its portion.

Initial Steps. A steering committee was formed consisting of the CMHS executive director, the special education director, an assistant superintendent, an assistant administrator in CMHS, and the program administrator for New Directions. Its function was to resolve issues by setting budgets and defining policy. Training was conducted with administrators of "sending" school districts; program staff were trained for one and one-half months; and the Independence LEA concentrated on training for teachers to insure that appropriate referrals were made. The plan was to run a cost-free service beyond regular local tax contribution.

RESULTS:

Budget. At the time this program was documented, it had not reached a break-even financial point. In 1980-82 CMHS lost $12,000 on the program. CMHS believes, however, that it will be able to market its services. Efforts are being made to establish a third-party and private payment system. The Independence LEA expects that tuitions from other districts will eventually allow Independence to reduce its personnel costs to near zero.

Benefits to Clients. In two years of operation approximately four students have been integrated into regular education programs; and several children have been de-institutionalized to the local program. As a public institution, the school district was unable to mandate parental involvement. However, since CMHS is a private program, parent participation may be made mandatory for a child's placement in New Directions. Additionally, parents can now see that structuring their child's environment twenty-four hours a day improves progress. As parents see progress, they become more involved and feel more in control. Parental and staff relationships have resulted in fewer communication breakdowns and in cost savings by avoiding the need for crisis intervention capabilities.

Quality Services. Location of the program in an Independence LEA school building has provided access to a range of professionals. What has emerged is a better understanding of each professional's unique contributions to providing the highest quality program to children with severe emotional disturbance. Separation of administration and policy issues from program issues has resulted in better program focus by New Direction staff. They indicate that there are no supervision problems even though educational staff are employed on a nine-month contract and mental health center staff are on twelve-month contracts with varying days off.

CONTACT:

Dr. James N. Caccamo
Director of Special Programs
ISD #30
1231 South Windsor
Independence, MO 64055
Phone: 816/833-3433

EDUCATIONAL-THERAPEUTIC SERVICE TEAMS

Virginia Beach, Virginia

Educational-Therapeutic Service Teams for Emotionally Handicapped Children, funded through Mental Health

DESCRIPTION: The Virginia Beach, Virginia Public Schools have collaborated with the Virginia Beach Department of Mental Health and Mental Retardation (MH/MR) to establish a model project funded through the State Department of MH/MR. The purpose is to integrate the therapeutic services of a mental health program with the educational services of a school-based program for seriously emotionally disturbed children, ages five to twenty-one, who reside within the city of Virginia Beach.

Educational-Therapeutic Teams. The model called Educational-Therapeutic Service Teams for Emotionally Handicapped Children consists of four teams providing educational and therapeutic services in thirteen self-contained classes: elementary, junior high, and senior high levels. Each class includes a maximum of ten children, one teacher certified for the emotionally disturbed, and one teacher's aide. Each team involves one mental health professional and the educational personnel from at least two self-contained classes.

Team roles. For each child the team prepares a comprehensive plan that employs psycho-educational and therapeutic strategies. A plan consists of at least three components: 1) The academic program, primarily the IEP; 2) the behavior program, designed to increase the frequency of adaptive behaviors; and 3) the family program, therapeutic services for families. A team also provides liaison and advocacy services on behalf of students and their families to various agencies and professionals. Teams also co-ordinate and plan re-entry into appropriate classroom situations.

Agency Roles. The academic program, primarily the responsibility of the educational professionals, takes place in the school setting. However, clinical staff on the child's study team give input in the development of the IEP. Upon request clinical staff participate in goal setting, provide supplemental diagnostic services, and provide ongoing consultation for inservice to teachers. Although education has primary responsibility for behavioral programs, the clinical staff are available for consultation and for individual or group counseling in the school setting. The family program is primarily the responsibility of the clinical staff, with involvement of the educational staff as appropriate. That program involves parent counseling, parent discussion groups, parent workshops, and family therapy.

DEVELOPMENT: During the 1978-79 school year, the Virginia Beach Public

Schools experienced a twenty-two percent increase over the preceding year in the population of severely emotionally disturbed students. The schools were then unable to serve those one hundred and sixty-seven students who required placements out of the community at exceptionally high costs.

A Proposal. The LEA contacted the local Department of MH/MR and suggested a joint proposal. It was submitted to the State Department of MH/MR in July 1979, and the project became operational in 1980. The goals were to 1) reduce the duration spent in self-contained classes; 2) increase participation in regular education classes; 3) reduce the number of students requiring residential placements and short/long-term hospitalization; and 4) reduce the residivism rates of those leaving self-contained classes, residential placements, and psychiatric/hospital facilities.

Expanding Relationships. The project began with nine self-contained classrooms and added four more during the second year. Key co-ordination/communication points were established at the administrative level between the Director of Comprehensive Mental Health Services and the Director of Special Education. Similar relationships were established at the operational level between the Mental Health Supervisor of CMHS and school administrators of the facilities that housed the self-contained classes. The Director of Special Education met monthly with the teams and reviewed progress/problems from both a clinical and an educational perspective. MH/MR staff in the schools shared information about policies, directives, and mandates that encourage or discourage service co-ordination. This information is now communicated with the respective state agencies as input for the design of new, more faciliative systems and policies.

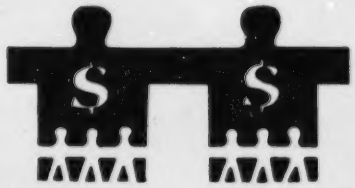
Resources. Funding for the program for the first period (less than a full year) was $57,310. Funds for the second and third years were just over $100,000 each. Funds for the latter now come primarily from city and state funds budgeted to the local Department of MH/MR.

RESULTS: As a result of the co-operative arrangement, more students are being referred to and treated by the comprehensive mental health services unit. Fewer students are being referred out of Virginia Beach to short and long-term care facilities, and more are being maintained in the local school setting. Residential placements decreased from forty to four per year at an estimated savings of $1,000,000.

CONTACT:

Howard Cullum, Executive Director
Virginia Beach Community Services Bd.
Pembrook Office Park
Pembrook 6, Suite 218
Virginia Beach, VA 23462
Phone: 804/499-3737
OR
Dr. Thomas Curran, Director
Department of Special Education
Virginia Beach Public Schools
Virginia Beach, VA 23462
Phone: 804/427-4778

REGIONAL INSTITUTE FOR CHILDREN AND ADOLESCENTS (RICA)



Montgomery County, Maryland

A "Regional Institute for Children and Adolescents (RICA)," jointly operated by the Maryland Department of Health and Mental Hygiene (DHMH) and the Montgomery County Public Schools (MCPS)

DESCRIPTION: RICA provides residential/day treatment services, along with education, to emotionally disturbed students ages six to twenty.

Cases. Students are placed in RICA through Montgomery County's local Admissions, Review, and Dismissal Committee because they have not been able to succeed in special education classes in regular schools. All students have average or above average intellectual functioning but exhibit severe behavior disorders. Eight beds of the evaluation unit are used exclusively by county juvenile judges although only home educational services are provided for those cases.

Staff Roles. RICA clinical staff support the educational program through crisis support and through behavior monitoring and liaison with other mental health professionals. Education staff likewise participate in therapy meetings. Staff members at RICA form treatment teams responsible for a number of students. Each team is made up of a primary therapist, an educational advocate who serves as a homeroom teacher, a residential supervisor, a services therapist, and any special subject teachers involved with a particular student. To integrate education and treatment plans as much as possible, RICA has made it a policy to insure that social/emotional goals are jointly developed by education and clinical staff. Teams meet weekly to review progress and problems. Every three months a team sets new goals for a student and re-evaluates individual education and treatment plans for consistency. A variety of daily behavioral monitoring techniques are used and with results discussed in small group sessions at the end of the day. RICA staff meets twice monthly with county judges who handle juvenile cases. RICA also performs out-patient assessments that include psychiatric evaluations for the courts at no charge.

Structure. The school component is operated under the direction of a principal as a regular school. The therapeutic component, which is interwoven with the educational component, is under the supervision of a psychiatrist and a clinical co-ordinator. Both report to the RICA chief executive officer jointly selected by DHMH and MCPS. The school principal works closely with the chief executive officer but reports to MCPS. An interagency board advises RICA officials on matters concerning potential conflicts with other community facilities or agencies. RICA also has a citizen's advisory committee that is actively involved in the budget process and serves an

important public relations function.

Resources. DHMH provides 4.6 million dollars, of which almost one million is contracted with the LEA to provide the majority of the educational component of the program. In addition MCPS uses nearly $600,000 of its own money toward education at RICA. Neighboring counties contribute a sum representing student tuition costs. The one million dollars provided by DHMH is equal to the minimum number of teachers times the average teacher's salary. Montgomery County has chosen to go beyond this staffing by supplementing it with county school funds. The MCPS also provides speech and language therapy as an in-kind contribution.

DEVELOPMENT: In the early 1970's the Maryland General Assembly was concerned about the rising costs of placing students outside school districts and about reports that appropriate services were not being provided in many facilities. A commission was formed to study the issue. At the same time, DHMH recognized a rising incidence of children with emotional disturbance. Two RICA-type models were already in existence: one in Catonville, Maryland (for young children) and one in Prince George's County.

Feasibility Committee. In 1971 DHMH initiated a committee to study the possibility of a residential facility. The original committee, consisting of representatives from DHMH, MCPS, the county health department, and other community representatives, met over a six-year period to work out the details of the project.

Funding. After preliminary negotiations, each agency submitted separate budgets for approval. The original DHMH budget did not contain funds for education. As the state budget office wished to use RICA as a precedent for insuring that all funds follow children, they expected that DHMH would have proposed funds for education. Budgets were resubmitted to include education, and an arrangement with Montgomery County Schools was developed to allow county funds to be used in a public facility. This set a precedent for treating public facilities in Maryland as private ones with respect to the requirement of county contributions. An agreement was signed in 1980 that assigned service responsibilities and funding requirements for operation.

RESULTS: In 1981-82 RICA graduated sixteen students and returned twenty-one to the public school system. While some of the former continued private therapy and some of the latter received resource room support, none were hospitalized. Costs for Montgomery County Public Schools are significantly less than when students were sent out-of-district. Due to the contribution by DHMH, Montgomery County's cost for RICA are less ($3,300) per student than costs in the regular public school system. DHMH is paying $5,067.00 per student for education and $18,000.00 per student for treatment.

CONTACT:

John L. Gildner, RICA
Chief Executive Officer
15000 Broschart Road
Rockville, MD 20850
Phone: 301/251-6800

REGIONAL TECHNICAL HIGH SCHOOL

Harwich (Cape Cod) Massachusetts

A Regional Technical High School with a population of 20-25% who have handicaps and are served through regular programs and an "Assessment Center and Work Place"

DESCRIPTION: Cape Cod Regional Technical High School, part of Massachusetts' regional vocational educational network, has worked co-operatively with the superintendents and special education directors on the Cape to extend the full range of prevocational, vocational assessment, and vocational education programs to children with special needs. Nearly twenty-five percent of the high school's students have been identified as having special-needs under Massachussetts state regulations.

Work Place and Assessment Center. Two programs have been specially designed to extend vocational educational programs to the school-age and adult population with more severe handicaps. The "Work Place" is an extended day program that provides concentrated skill training in specific occupational clusters, placement and supervision in job training, and job placement. The second special program -- "The Assessment Center" -- works with local, regular, and special education staff to perform comprehensive vocational assessments. The five-day assessments, normally performed before students enter eighth grade, are used to identify appropriate vocational programs and as the basis for comprehensive, long-range planning.

Cases. Cape Cod Regional Technical High School accepts referrals from any agency in the Southeast Region. Services are provided to special-need students with an emphasis on those in eighth grade or above. The Assessment Center is, however, used by younger students with severe/profound handicaps for whom a long-range plan might involve a residential placement.

Procedures. Special services is viewed as a visible and integral part of the overall school program. Special services staff act as crisis intervention teams in the regular classroom. On an ongoing basis, staff members seek referrals from sending districts. Additionally, high school staff attend junior high school IEP team meetings to insure that a co-operative effort exists between the sending school and the high school before the child enters.

Administration. The special service director has contact with the "school committee" (school board), consisting of two members from each of the twelve towns served by the High School. That committee is kept fully informed of program activity and policy issues. Communication is also maintained with each town's finance committee, a representative of which is sent to the High School's finance subcommittee for

a series of meetings. At that time the High School's budget is reviewed.

DEVELOPMENT: Massachusetts Chapter 766 was passed in 1974, toward the end of a planning process for the Regional Technical High School. At the time of this special education mandate, planners took the position that the intent of the law was to provide as many options as possible for special-needs students. The commitment was made to involve special-needs students in regular classes with whatever aid and assistance was needed. In 1975 school opened, and proposals were written to Occupational Education and Special Education for funding of staff. A co-ordinator of special education, a lead teacher, and nine instructional aides were originally funded through the two divisions and through the LEA budget.

Need for additional services. Out of priority setting by this board grew a training program for students who either didn't apply to the High School on their own or who didn't want to go to school full time. Recognizing a need for additional joint vocational programming for special-needs students, the Division for Occupational Education and Division of Special Education merged federal funds and issued RFPs for extended programs. The co-ordinator of special education again worked with the local school district special education directors to propose an extended day program that subsequently was called the "Work Place." Contacts were made with Comprehensive Education and Training Act officials to obtain funding to pay students for their skill training participation in the afternoon program. During the same time period, a proposal was developed through PL 94-482 funds for an "Assessment Center." This proposal involved contacting all school districts and asking them to transfer their set-aside funds to the Regional Technical High School.

RESULTS: Prior to the opening of the High School, there was no vocational education program available on the eastern end of the Cape to students with handicaps. Although there are still difficulties in placing students after high school, there has been a significant increase in the number placed in positions.

Agency Involvement. The Work Place, originally designed to serve drop outs and potential drop outs, has become a vocational education resource for all agencies on the Cape. Ongoing communication with the school committee and the town finance committees has meant that this unit has never had their budget turned down. The regular special education program and the assessment center are now funded through LEA budgets rather than grants. Extensive involvement with outside agencies has provided a better perspective of client need, service availability, and appropriate referral. The outreach program has been critical in identifying both children and gaps and overlaps in services.

CONTACT:

Marcia Hekking
Director of Student Services
Cape Cod Regional Technical H. S.
Pleasant Lake Avenue, RFD 4
Harwich, MA 02645
Phone: 617/432-4500

INTERAGENCY PRESCHOOL COLLABORATION PROGRAM

Salina, Kansas

A preschool program jointly operated by over 20 agencies

DESCRIPTION: The Interagency Preschool Collaboration Program is comprised of several co-operative activities on the part of human service agencies in the central Kansas area.

Co-operative Efforts. The agencies co-operate on public awareness, a high-risk registry, screening, evaluation, follow-up medical evaluation, and direct services. Activities are co-ordinated through a full-time administrator who provides a common referral point, a clearinghouse, and case management for preschool children. Two interagency teams meet on a monthly basis. The first team consists of administrators of the various agencies, and the second consists of direct service providers from the same agencies.

Agency Involvement. In addition to an educational co-operative representing twelve LEAs, participating agencies include hospitals, a mental health center, the crippled children's program, social and rehabilitative services, an occupational center, preschools, day-care programs, physicians (especially pediatricians), the public health department, the state education agency, and the Department of Health and Environment. Agency involvement in the various program components is shown in the figure below.

Agency Involvement

AGENCIES \ PROGRAM COMPONENTS	PUBLIC AWARENESS	HIGH-RISK REGISTRY	SCREENING	EVALUATION	SECONDARY MED. EVAL.	DIRECT SERVICES
HOSPITALS	*	*	*	*	*	*
MENTAL HEALTH CENTER	*		*	*	*	*
CRIPPLED CHILDREN'S PROGRAM	*		*	*	*	*
SOCIAL & REHABILITATION SERVICES	*		*		*	
EDUCATIONAL COOPERATIVE (12 LEAs)	*	*	*	*	*	*
OCCUPATIONAL CENTER OF CENTRAL KANSAS	*			*		*
CHAPTER I	*		*			*
PRESCHOOLS	*			*		*
DAY CARE PROGRAMS	*					*
PHYSICIANS/PEDIATRICIANS	*	*	*	*	*	
OPTOMOTRISTS	*		*		*	
PUBLIC HEALTH DEPARTMENT	*		*		*	
DEPARTMENT OF EDUCATION					*	
DEPARTMENT OF HEALTH & ENVIRONMENT					*	

Resources. Agencies contribute staff time for the various program components and are reimbursed through their standard funding mechanisms (e.g., third-party payers, state funding, ADC). The program is evaluated annually by university students who interview agency personnel and report to the two interagency teams. No cost is charged for the program evaluations.

DEVELOPMENT: The Kansas SEA, using a state implementation grant, assigned a field co-ordinator to organize a meeting of agencies in the Salina community that were interested in developing interagency preschool programs. A number of informal meetings followed. During this time the SEA field co-ordinator played the critical role of resource person and process guide for the local leadership. Informal planning sessions were attended largely by direct-service providers from several different agencies who made a volunteer commitment to meet regularly. Needs were defined, the goals of their organizations were examined, and standards of service were jointly developed.

Proposal. After eighteen months of planning, the group decided to pursue a VI B grant from the SEA to fill a fulltime co-ordinator's position. At this point the educational co-operative became the sponsoring agent for the grant. The local project co-ordinator position was filled by the person who had formerly been the SEA field co-ordinator. At that time the two teams were formally established. Initial efforts were made in establishing joint screening clinics and developing an awareness campaign.

Free evaluations. Arrangements were made with a local university to have a student working for a grade and credit to conduct a third-party evaluation of their program at no cost.

RESULTS: Interagency involvement in this program has resulted in greater awareness in the Salina area regarding the need for preschool services. Parents are more willing to seek out services, partially due to no cost for screening. The number of handicapped children served in the preschool educational program approximately doubled, and there was a perception of an improvement in quality as well. The range of services available to handicapped children has increased due to the number of agencies involved and the increased access to information about eligible children. Those identified from screenings as having a handicap are tracked by the project co-ordinator who serves as case manager and insures continuity of service. Thus, fewer children have "slipped through the cracks." Agency participants now feel if VI B funding is withdrawn, the program will continue with agencies supporting the case management and clearing house functions of the co-ordinator.

CONTACT:

Janell Mulvenon
Interagency Project Co-ordinator
Central Kansas Co-operative in Education
3023 Canterbury Drive
Salina, KS 64701
Phone: 913/823-7263

CHAPTER 5
RESOURCE POOLING

> The joy of this quest is not in triumph over other but in the search for the qualities we share with them and for our uniqueness, which raises us above all competition.
>
> Theodore Roszak

The relationships among some agencies have matured to the point where they co-operate, not to compete, but to capitalize on the unique talents, structures, and capacities of the participating agencies. To be sure, the agencies have fiscal reasons for co-operating; but they have overcome barriers to sharing efforts and have effected a program that addresses a common purpose without emphasizing interagency rivalries. This chapter provides some ideas on how LEAs might go even further in collaboration. In the previous chapter we described agencies that co-operated to obtain external funding. The practices described in this chapter involve re-allocating internal resources toward co-operative, mutually beneficial efforts. We call it "Resource Pooling."

Strategy Description

Resource pooling is a strategy selected by co-operating agencies who have shared mandates and needs to serve specific populations. Common populations include children with emotional disturbances, preschool children, and children with severe and profound handicaps. Agencies agree to merge resources, increase the range of services, or increase communication and thus decrease duplication. Pooling may involve contributing staff time to a specific interagency function, merging efforts with another agency to establish a needed program, sharing expertise across LEA borders, or LEAs co-operatively developing rate schedules and contracts with related service providers.

Direct Impact. Resource pooling has direct benefits to LEAs. Pooling reduces duplication, as each agency contributes its unique skills to the effort. Resource pooling also increases communication and establishes a common information base for agencies dealing with particular problems. Registries and data-tracking systems appear to be common outcomes. The sites we visited indicated that resource pooling reduced overall cost, largely through reduction of duplication. At the same time, resource pooling increased the range of services available to any one agency. Resource pooling is especially useful in rural areas. By defining unique contributions of different agencies, more comprehensive services may be provided to persons with handicaps than could be provided by a single agency.

Indirect Impact. Resource pooling

also has an indirect result on political and social processes. Agencies that have agreed to contribute staff time and services can parlay their contribution to insure more comprehensive services. For example, school districts cannot require parents to participate in programs for children with emotional disturbance. However, in a number of sites that we visited, co-operating mental health agencies were willing to place a parental involvement requirement into their program because their mandate allowed them this flexibility of demanding such involvement. The school districts were then able to insure parental involvement by deferring to the mental health mandates. Co-operative programs also have demonstrated political power. The agencies can go to their ruling bodies as a group, demonstrating that their co-operative efforts are fiscally responsible and that needed additional allocations will be used wisely.

Considerations for Replication

Based on our experiences there are at least five considerations to be made when developing a resource pooling strategy.

1. Establish common needs. In order for agencies to commit staff, facilities, and equipment to a common effort, both staff and administration must perceive common needs. Needs may be defined by common mandates (e.g. for emotionally disturbed, preschool, or severly handicapped children). Co-operating agencies must perceive that resource pooling will benefit each agency as described above. It is critical in the initial stages of defining a common mandate that participating agencies agree to base all decisions on children's needs. Otherwise, resource pooling may be based on administrative convenience and will ultimately result in problems.

2. Obtain leadership and support. The majority of the sites that demonstrated resource pooling had evolved naturally from a single agency's initiative through comprehensive agency involvement and administrative support. In some cases the administrators had taken the first step and had either assigned staff to develop agreements or had developed general agreements themselves. In other cases a direct service individual in a particular agency had taken the initiative to call others together. Each individual then garnered support from his or her individual agency's administration. There was a typical attitude of "I'll keep doing this until someone says that I can't." Demonstrated success sometimes led to administrative support.

3. Allow for team ownership. It is essential that the agencies involved in the resource pooling activity perceive the pooled activity as their activity rather than the activity of another agency with which they are collaborating. In most cases this was handled by administrators who hired staff in whom they had confidence and then allowed the staff to interact in team planned activities. Team ownership of the final product resulted. This approach is consistent with Gill's (1982) observation that "Problems at a given level of operation in your organization can be solved by the employees who are the most expert in the operation at that level." It is

essential that staff who are assigned to such planning activities are committed to team planning and not to specifically protecting the interests of their own agency.

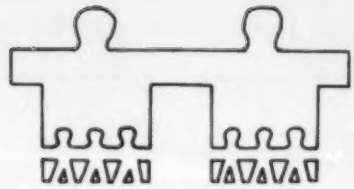
4. Use an interdisciplinary approach. Related to team ownership is the concept of the interdisciplinary approach. In the interdisciplinary approach, persons representing different disciplines are willing and able to work with each other in the development of jointly planned programs for individuals and groups and to assume responsibility for providing needed disciplinary services and treatment as part of a total program. Such an approach goes beyond a multidisciplinary approach in which each discipline makes a contribution but there is no group decision making. The approach does not go as far as a transdisciplinary approach where individuals no longer represent their agency or discipline but provide services that are considered the responsibility of other disciplines and agencies.

In the interdisciplinary approach, it is essential that participants clearly define their roles. These roles may emerge through the process of working together and then should be documented for future reference. In the long run, a clear definition of roles eliminates unnecessary duplication. As a member of an interdisciplinary team, an educator should take a strong stance for the unique contributions of education in an individual's total habiliation program while recognizing and respecting the contributions of other treatment and supportive services. By working together on specific cases, representatives of various agencies will begin to trust each other and feel more confident in sharing planning decisions.

5. Ensure fiscal freedom. There are two components to insuring fiscal freedom for agencies involved in a resource pooling strategy. In the first place, resource pooling appears to work best when there is independence from state and federal fiscal structures. None of the interagency relationships cited as examples in this chapter are supported through federal or state grants. True, each agency receives federal or state money; but the co-operative effort is not funded through external sources. This allows freedom for the team to make program and fiscal decisions. The second condition that must be met is that private agencies involved in a team effort should be insured that they will not lose money by co-operating. For example, co-operation in a free screening clinic will very likely lead to increased referrals for direct service and thus insure additional income rather than loss of income for a private agency. Agencies should establish relationships that insure there is no competition for direct service funds.

The four site descriptions that follow meet the conditions cited previously. Each site is described in terms of its resource pooling activity, how the activity developed, and the results the strategy obtained.

PRESCHOOL SCREENING CLINIC



Weld County (Greeley), Colorado

A monthly preschool screening clinic operated through in-kind agency contributions

DESCRIPTION: Weld County is a large, mostly rural county in Northeastern Colorado. During the 1981-82 school year, a group of public and private agencies began a co-operative screening program for children aged birth through five who might be developmentally delayed. The object of the program was to identify high-risk children and refer them to appropriate services before school age.

Cases. The program screens any child who resides in Weld County, is referred by a parent or professional, and is suspected to be at risk of developmental problems. There is no fee for services and no limit to the number of times a child can participate in the once-a-month screening. Any child who resides in Weld County, is referred by a parent or professional, and is suspected to be at risk of developmental problems may be screened.

Procedures. Upon receipt of referral, parents are contacted by phone for an explanation of the screening procedures that include the following: hearing, physical health, general cognitive development, fine and gross motor abilities, receptive and expressive language, neuro-motor functioning, family environment, and vision. Approximately twelve to sixteen children are seen each month. Following a screening the total team discusses recommendations for agency follow-up and parental actions. The program co-ordinator then writes a summary of findings and recommendations. A copy goes to the parents, to the referring and/or receiving agency, and to the local school district.

Agency Contributions. Agencies contribute staff time and provide their own equipment as follows:

- Weld County Community Center: Program co-ordinator and psychologist, OT, PT, and speech and language
- County Department of Health: Public health nurse and staff to help parents with adaptive equipment requests
- Greeley School District: Audiologist, vision specialist, child-find co-ordinator
- Weld BOCES: Child-find co-ordinator, vision-specialist, and PT
- Northeast Health Care (for lower income): Public Health Nurse
- Rehabilitative and Visiting Nurses Association: OT, PT and an RN
- Univ. of Northern Colorado: Graduate students in speech/language and audiology; and nursing practicums
- Northern Colorado Medical Center: PT and OT
- Headstart: Spanish translator
- Nursing Home: Space including a soundroom for audiologicals

DEVELOPMENT: Several of the Weld County community agencies with responsibility to identify young handicapped children were duplicating home visits while having to purchase specialized services from each other. Because of high mobility, agencies needed a mechanism to identify and track children served by several agencies.

Planning. An interagency child consortium was formed in 1977. They prepared a proposal, but it was not funded. The interagency children's consortium was reconvened in 1980 with representation of staff workers from each agency. They drew upon a model program developed by the SEA in Colorado called Project ECHO and private agencies jointly screen, diagnose and treat infants and preschool children in another county. Each staff representative obtained approval from their agency directors to participate and contribute professional staff time. In-kind donations were arrived at largely through a process of self-examination. Each agency asked what professional expertise it possessed that could benefit the screening program. Some agencies concerned about the loss of income for diagnostic services joined in the program on a pilot basis. No formal contracts for agreements were signed.

RESULTS:

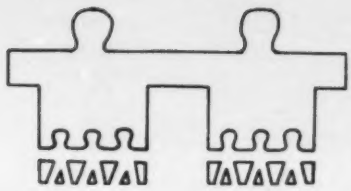
Positive effects on children. The program identified approximately three times as many children for the 1981-82 school year as individual programs had collectively identified in 1980-81. Where it previously took several weeks for one agency to screen a child, the interagency clinic completes screening in a single day. Interagency staffing insures that a full range of services is considered for each child and that the staff can provide access to their agency's service. Interagency screening allows "at risk" children to be tracked during preschool years without being labeled handicapped. Interagency screening provides an entry point through which a child's progress is noted. This is expected to minimize future problems.

Benefits for Agencies. Benefits that accrue to various agencies ultimately result in improved services for children. Duplication of screening and other services has been reduced. Consolidation of staff and equipment resources has allowed agencies to maintain screening levels with smaller staff and identify mutually exclusive functions for themselves. School districts are better able to plan for their school-aged population with computerized records on the projected number of students. Agencies have begun to understand each other's roles and have begun to collaborate on other programs (e.g., adult services). The impact of greater awareness and respect is an enhanced relationship outside the screening clinic.

CONTACT:

Ms. Deb Fletcher
Child-Find Coordinator
Weld County School District #6
811 15th Street
Greeley, CO 80631
Phone: 303/352-1543, Ext. 271

SPECIAL EDUCATION STAFF RESOURCE POOL



Upper Peninsula (Escanaba), Michigan

A semi-formal agreement (The Special Education Staff Resource Pool) among intermediate school district (ISD) special education directors in the Upper Peninsula of Michigan

DESCRIPTION:

Information Base. The name of various staff members with specific areas of expertise are placed on a list and made available to assist other ISDs in the Upper Peninsula. The intent of the system is to increase the availability of expertise in all ISDs without significantly increasing costs. Each school district completes a simple one-half page form on staff members. The forms are limited to personnel who have specific skills and/or areas of expertise that might be appropriate and available to other ISDs. It is suggested that ISDs include staff who could assist with diagnosis, inservice workshops, third-party assessments, and consultation. This information is compiled by the Delta Schoolcraft special education director and sent to all other ISD directors.

Procedures. When an ISD identifies needs for a staff member from another ISD, a letter is written to the director of that ISD requesting the services of that person. At the bottom of the letter a space is provided for the contacted ISD special education director to sign as concurrence with the request. The requesting ISD then reimburses all travel, meals, and phone costs for the staff member. The services provided are not usually direct services although assessments are sometimes provided. More frequently, the services involve workshops and consultations.

Maintenance. Maintenance of the system requires minimal effort because Upper Peninsula special education directors meet frequently and the Resource Pool is an agenda item as necessary. Each director takes responsiblity for maintaining his or her portion of the Resource Pool. There is no grant financing for maintenance of the system.

DEVELOPMENT: The Resource Pool was initially developed as a part of a Title IV federal grant. The design for the Resource Pool called for each school district to exchange staff members at no cost and in equal amounts. This soon became a problem as the larger school districts, with a broader range of staff expertise, were constantly receiving requests for services; whereas the smaller school districts had no drain on their resources. The directors have now agreed that when a staff member is requested on a regular basis and no trade may be arranged, a rate equivalent to the daily salary of the selected staff members may be charged.

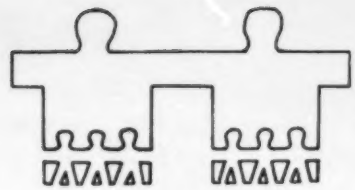
A second problem was resolved

regarding who was to be listed as part of the Resource Pool. When the system was initiated, it was cluttered with the name of every staff person in every ISD. The directors found that the task of searching for someone with specific skills was too difficult and subsequently agreed to limit their listing to persons who have unique skills.

RESULTS: As a result of the Resource Pool, ISDs have found it unnecessary to hire full-time staff who might have only part-time functions, or to pay for high-cost consultants. By using personnel employed by other school systems, there is little need for orientation to school regulations or procedures. These staff are also familiar with the service agencies' style of delivery and other contextual factors characteristic of the Upper Peninsula.

CONTACT:

John Lindholm
Special Education Director
Delt.-Schoolcraft ISD
810 N. Lincoln Road
Escanaba, MI 49829
Phone: 906/786-9301



PROGRAMS FOR CHILDREN WITH BAHAVIOR DISORDERS

Des Moines, Iowa

A co-operative program for children with behavior disorders to provide related services including family therapy, psychotherapy, and residential services through arrangements with a variety of agencies including a private residential center, a private mental health organization, hospitals, and family service agencies

DESCRIPTION: The Des Moines Public Schools serve nearly 31,000 students. It provides educational services for a population of over 500 children with behavior disorders.

Orchard Place. The LEA operates one diagnostic and seven self-contained classes, for children with behavior disorders, within a private non-profit residential facility called "Orchard Place". Sixty-five percent of the children served at this center are tuition students from other LEAs for whom the Des Moines LEA obtains reimbursement for educational services. Direct-care costs at Orchard Place are borne by the Department for Social Services through Title XIX funds. Medical expenses are paid through third-party payers. Orchard Place also obtains funds from endowments and gifts. Instructional staff serve as members of a team including education, therapy, and "milieu" (i.e., residence counselors, nursing, and recreation staff). Placements are co-ordinated with the area education agency to insure proper processing and to arrange for reimbursement from the state. School services are provided through as normalized a setting as possible, but parents are required to participate in planning sessions and therapy. Children rotate for classes as in a regular school setting and are integrated into the Des Moines public schools as early as possible. A co-operative, integrated program for adolescents has recently been developed with Orchard Place.

Child Guidance Center. The Des Moines LEA operates two classes at the Center that serve as a "day hospital." One is a diagnostic class that allows short-term services to children who have not been identified for placement. The school district assigns an LEA liaison to the three teachers (LEA employees) at this private center. Treatment services (other than education) are reimbursed through individual contracts with families and the Department of Social Services.

Hospitals. Each of two major hospitals operate a treatment program for individuals with behavior disorders and are reimbursed through third-party payment. The school district has developed a relationship that establishes classrooms in the hospitals to serve a maximum of twenty

youths.

Children and Family Services. Iowa Children and Family Services provides in-home treatment services and emergency foster care placements in conjunction with in-school programs in the Des Moines Public School System. Treatment services are funded through state Children and Family Service dollars.

DEVELOPMENT:

PL 94-142. Prior to PL 94-142, there was little relationship between educational programs in regular school facilities and those in more restrictive placements. Planning was done independently by social services and mental health agencies; LEAs only provided funding. After PL 94-142, Des Moines and other LEAs demanded direct involvement in planning each child's program before resources would be allocated. There was a growing awareness that the entire family needed to be treated. The agra-education agency served as a catalyst to establish a memorandum of agreement regarding entrance, referral, exit, and suspension procedures. (See report on Polk County in Chapter 2.) Specific memoranda of agreement and policies and procedures were developed with each of the co-operating agencies. Under the new agreement, all hiring of educational staff is done by the Des Moines Public Schools.

Psychotherapy Excluded. A decision by the SEA to preclude reimbursement for psychotherapy services by school districts allowed each education agency to negotiate agreements that limited their contributions to educational services.

RESULTS:

Parents. Parents have improved attitudes regarding school and service delivery agencies. They believe that their children are now capable of learning, that their situation is not hopeless, and that their child's behavior can be managed. The availability of in-home service programs has facilitated transition to the home and has decreased residivism.

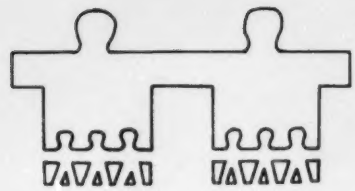
Program Staff. Treatment, "milieu," and education staff have changed perceptions about each other. Each group has learned about the contribution the other can make. Staff meetings have become staff development sessions to learn techniques, procedures, and theories in other fields to reduce staff anger and frustration. This results in less of a tendency to give up or to respond inappropriately.

Organizational Structures. As a result of interagency co-operation, there is now a systematic transition procedure for ongoing communication and criteria for the child to enter and exit the program. Until now, in many cases, the school system was unaware that therapy services were terminated or that the child was going to be dropped from the program. Now education is seen as an equal partner.

CONTACT:

Mr. John Epp, Supervisor
Behavioral Disorders
Des Moines Independent Community School District
1800 Grand Avenue
Des Moines, IA 50307
Phone: 515/284-7714

A CONTRACTUAL SERVICE "POOL"



Gardiner, Maine (South of Augusta)

A contractual service "pool" from which school districts purchase needed services for low-incidence and severe handicaps

DESCRIPTION: Eight school districts in Maine's capitol area region have collaborated to develop common contracts with related-service providers. Services for which regional contracts have been developed include psychology, psychiatry, OT, PT, speech and lagnuage, pediatrics, expressive therapy (music, art, dance), and vocational evaluations. Region-wide contracts are negotiated with related providers that establish uniform rates. Because they are developed jointly for all districts, they serve to hold prices for services at uniform levels. Providers agree in these contracts to bill third-party payment sources first; the districts pay for services if no other funds are available.

DEVELOPMENT: When small districts such as these brought even one child back from a private residential setting to a district-based program, it required access to services that were not available or funds that could not be squeezed from individual school budgets. Confronted with resource limitations, the eight special education directors began efforts to put in place two mechanisms: (1) region-wide contracts with related-service providers, and (2) a funding strategy that uses third-party payers such as Medicaid as well as a "pool" of funds to be used for services that no one district could afford.

A Title IV grant was obtained to initiate the program, with a focus on low-incidence children. Since that time the districts have been able to maintain the pool through allocated state and tax funds rather than discretionary project funds.

RESULTS: The regional system of related-services provision has had several effects. It has increased access to services by making related services readily available to all parts of the region. It has lowered costs to each district by tapping other funds and by holding provider rates constant. It has also created an issue around which the special education administrators convene their superintendents to demonstrate cost-effective service planning and to obtain support for further mutual efforts. Finally, it has created a well-organized service delivery network that allows districts and providers to efficiently allocate resources.

CONTACT:

Richard Abramson
Main School Administrative District #11
Gardiner Regional Junior High School
RFD 5A
Gardiner, ME 04345
Phone: 207/582-7366

CHAPTER 6
WHAT HAVE WE LEARNED?

> To reach port we must sail, sometimes with the wind, and sometimes against it; but we must sail, not drift.
>
> Holmes

What have we learned from looking at a variety of interagency relationships that deliver related services? There are two clear lessons. First, interagency efforts can have wide benefits to children and to LEAs in general. Second, collaboration is hard work; such relationships don't just happen.

Benefits

Increased Range of Services. A universal benefit when LEAs get together with other agencies that represent different mandates and a variety of professionals is that children receive a broader range of services. There is more attention to total life situations and families; more emphasis on prevention, and a clearer commitment to follow-through. This phenomenon was reported not only by LEA staff but by other agency personnel as well.

Increased Quality. An interesting by-product occurs when people representing different disciplines and agencies get together and begin discussing a problem. The result is increased quality of decisions and programs. In all sites we visited, it was clear that professionals in each agency learned from each other. By sharing their expertise, each professional was reinforced regarding his or her own skills. Team participants learned from each other and increased their range of skills. In some cases group decision making took a great deal longer than if agencies had made decisions independently. However, group ownership of a decision increased the probability of follow-through. Issues were explored from a variety of points of view; and the resulting decision took into account more issues than would likely have been considered by a single agency. The group process also produced an increased sense of accountability requiring attention to detail. This resulted in improved programs for children.

Reduction of Duplication. Representatives began to carve out specific and unique areas of service for their agency. The result was that LEAs could provide education and other agencies could provide "related services" (which represented their main treatment or habilitation thrust). We observed that LEAs engaging in interagency collaboration efforts directly hired fewer related-service personnel than did LEAs in our general sample. In some cases the LEA traded educational services in non-traditional sites in order to obtain related services from a co-operating agency. For example, the LEA might be required to establish a class in a hospital or residential setting in exchange for psychiatric assistance, occupational therapy, or physical therapy.

Fiscal Advantages. LEAs involved in interagency collaboration had not universally been able to decrease costs. But it is clear that no

co-operating LEA that we observed had significantly increased their cost. In most cases LEA dollars were displaced. Collaborating LEAs and other agencies move dollars to new priorities from what has become another agency's mandate. The level of services then goes up.

Organizational Support Benefits. There are a number of organizational support benefits in addition to staff development. An interagency team begins to serve the function of a local support group. Agency representatives find that they may use this group to field test ideas and to obtain input on handling situations within their agency. Another mutually agreed upon function is joint blame-sharing. An agency representative may wish to put forth an idea unpopular within his or her own agency, or to another population, but can hold the interagency group responsible for the idea. This allows the representative to promote an idea without appearing to be disloyal. Although joint proposal development was described in Chapter 4 as a specific strategy, it is a common outcome of interagency collaboration. Frequently an issue will arise for which there is no solution without outside help. In such cases each agency can draw upon the strength of the group in advocating for the new program before policy-making bodies or funding sources. Similarly, the interagency group may join together to advocate for policy changes, new approaches to programs, and/or changes in organizational structures.

Necessary Preconditions

In order for interagency collaboration efforts to be successful, there are at least three preconditions that must be met.

Permissive State Policies. None of the fifteen sites reported in this document had to swim directly against the tide of state policy. In some cases there were no specific state agreements or state policies that suggested local interaction; but there were no policies precluding such action. In a few cases, state policy directly facilitated local action. In order for local interagency collaboration to occur, the state must either create an atmosphere for collaboration or, at the very least, let it happen.

Broad Picture of Services. Successful interagency collaboration has occurred only in situations where "services to the handicapped" were perceived as more than education, more than health, and more than family and social services. There was a general community acceptance of the need for services to the handicapped. "Needed" services included the total life spectrum and the total family.

Examining Ourselves. The final condition for successful interagency activities involves a set of personal decisions to be made by participants on interagency planning teams. There appear to be a set of responses necessary for what Elder and Magrab call the "human factors" to take place. At the policy and direct service levels, affirmative answers are necessary for the following:

1. Am I here to help kids? -- Will I be addressing the needs of children and not systems, turf, and power?

2. Am I willing to help another agency solve its problems? -- Is this effort a joint effort for the betterment of all and not just something for me as an individual or for my agency?

3. Am I willing to accept responsibility to implement something I don't want to do to facilitate the group effort? -- Am I willing to trade?

4. Do I assume that other individuals on the team know some things that I don't know? -- Do I respect the other team members?

5. Am I willing to learn their systems? -- Will I make an honest effort to understand fiscal procedures, program mandates, and organizational structures?

6. Will I focus on solutions and not constraints? -- Will I be a facilitator or a barrier setter?

7. Am I willing to be open and honest? -- Will I present an accurate picture of my program and my needs, and react honestly to proposals and suggestions in the group setting?

8. Am I willing to relinquish the authoritative role? -- Will I share in decisions?

9. Am I willing to bend or stretch my rules in order to deliver quality services? -- Am I willing to look for alternatives and not lean on the letter of the law?

Anticipating Problems

Even if all three preconditions are met, and individuals have commitments to carefully examine themselves and openly participate in team processes, a number of problems are certain to occur.

Organizational Differences. The variety of organizations participating in an interdisciplinary process bring different organizational structures, funding mechanisms, and languages. These take time to learn, but as the team matures, a general understanding will emerge. Until that time, a number of frustrations are bound to present themselves. Particular problems seem to occur in understanding the different motivations of public versus private organizations. The necessity of operating at a profit, or at least at no loss, is foreign to public servants. Openness to the profit motive and the need to support staff through income is essential on the part of LEAs. LEAs need to understand third-party payments and especially Medicaid funding. It is important to remember that each funding source has different eligibility requirements. Failure to provide service may be a direct result of factors that may not directly effect LEAs. Additionally, language problems are certain to occur: Terms such as "evaluation," "screening," "referral," "individualized plan," and many others will be terms, which when used in team planning, are thought to be understood but in fact may be used with a completely different meaning from that commonly understood by LEA personnel. These several frustrations can lead to conflict unless the team members anticipate them and are prepared to recognize and deal with them.

Confidentiality and Record Transfers. No problem area was mentioned more frequently than transfer of records among agencies. The amount and type of data that can be transferred between agencies is frequently restricted by conflicting state and federal policies. Agencies enter into activities with different perceptions

of the level of information needed by other agencies. There are bound to be conflicts regarding the amount of information that can be exchanged. Working through these problems will make the team stronger and will insure that each agency fully understands the needs of participating agencies as well as its own.

Agency Changes. As the interagency effort develops, participating agencies should not expect the initiating agency to keep the effort alive. There will always be individual burnout for interagency efforts. When this occurs other agencies and individuals must be ready to accept responsibility for convening meetings and producing products. Second, individual and agency agendas will change over time. Consistent representation in interagency efforts will somewhat reduce this phenomenon. However, changes in regulations, allocations, organizational structures, and society will require reaction on the part of individual agencies. These reactions will be reflected in the stands that they take during interagency collaboration sessions. Such changes should not be perceived as capricious behavior on the part of representatives but simply evidence that they are reacting to a different set of circumstances.

Agency Reactions. Understanding and anticipating organizational differences, confidentiality problems, and agency changes are crucial to the interagency process. These areas represent points during which interagency interaction will result in conflict. As indicated earlier in this report, however, conflict can lead to increased understanding and even better collaboration. Conflicts should not be avoided but addressed head-on, in an open and honest manner, anticipating positive outcomes.

A Possible Scenario

There can be no single approach to the broad range of potential collaboration activities. Recognizing this doesn't prevent making suggestions regarding a few major events that should occur as the interagency process evolves. Developing interagency relationships, because of the interpersonal nature of such relationships, takes time. Whatever events are planned, they must allow for a slow, careful transition from single agency-single discipline activity to interagency-interdisciplinary planning. Since the sequence defined below will not apply in all situations, each group must choose their own course.

1. Start with a Specific. Agencies should begin dealing with a specific child and with the agencies active in that child's program. It is certain death to take on issues in isolation. Participation of agencies without a perceived need will involve agendas that are not conducive to team planning. Initial involvement should be limited to a specific number of services, a specific number of agencies, and specific classes of children.

2. Agree to Agree. It is important that early in the planning process the team decides about the issues upon which they really need to agree. The team should set aside unresolvable issues and focus on those issues for which they need to have solutions. This does not mean that conflict should be avoided, but

resolution of any conflict should further the group's purpose.

3. Policy From the Bottom Up. It takes a long time, but development of a generalized policy is anchored in reality. Additionally, team members can agree upon individual cases much more easily than a generic policy that is perceived as having wide-ranging effects. By gradually evolving policy through individual cases, it can be field tested before it is adopted.

4. Make Team Decisions. Throughout this document we have discussed the need for team ownership of decisions. Group decisions are usually the best decisions and result in commitment to follow-up.

5. Learn-Learn-Learn. Team members should get to know other team members, learn the language used by other agencies, and understand the mandates under which each agency operates. Informal sessions to "meet and greet" in addition to formal presentations are essential.

6. Plan for Each Agency. Broad range plans should address each agency's needs and specify follow-up steps. The issues of fiscal freedom, organizational structures, and individual and agency responsibility all need to be addressed in the interagency plan.

7. Publicize Co-operative Efforts. The community role in serving the whole child should be emphasized through use of media regarding co-operative efforts among agencies. This will promote the idea that the entire community is involved in serving these children.

8. Advocate as a Group. Once agencies have begun to collaborate and have developed community ownership of a broad range of services to persons with handicaps, the interagency group can begin to develop co-operative proposals, position statements, and advocacy efforts to deal with larger issues. The committee can promote legislative change, policy change, and new program efforts within local, state, and even federal entities.

9. Write it Down. Only after trust has been established should formal relationships be detailed. Generic descriptions of agreement should suffice until it is clear that agreement represents an historical relationship rather than a projected plan.

Conclusion

Throughout this report the dynamics of the team approach have been emphasized. Specific reference to individual related services has been underplayed. That is because the impact of individuals within agencies working with other individuals appears to be the single most important factor in obtaining related services. When a person shares a decision with another individual, both individuals are committed to the final product. In the issues presented in this document, such decisions lead to more and higher quality services for exceptional children.

APPENDIX

Procedures for Collaborative Data, Collection Analysis and Reporting

This study involved extensive collaboration with the Center for the Study of Social Policy (CSSP) in preparing protocols, gathering data, and reporting results. At the time this study was being planned, the CSSP was conducting a project for Special Education Programs (SEP) to identify exemplary policies and practices in the implementation of PL 94-142 and Section 504 of the Rehabilitation Act of 1973; to document and disseminate these in a form useful to decision makers; and to develop models to help SEP in further technical assistance efforts. (CSSP, 1980 Abstract)

SEP notified RRCs that collaboration with CSSP's project was essential to avoid unnecessary duplication of effort. A great deal of similarity was found in the two projects. CSSP staff were studying five areas of state and local policies:

Interagency Relationships

Placements in Least Restrictive Environments

Out-of-District Placement

Monitoring

Related Services

It was agreed to work together on the interagency and related service areas. The CSSP would emphasize state level policies as well as local policies; and their products would be broadly targeted on federal, state and local level decision makers. The RRC would emphasize local practices and the conditions that made them successful. After some additional planning with South Carolina, it was agreed that the audience for this document would be local level decision makers.

The CSSP conducted visits to thirty SEAs for the purpose of interviewing state officials and reviewing state policies. The CSSP sent a questionnaire to over 400 LEAs nominated for successful policies in one or more of the five CSSP areas after obtaining necessary forms clearances. Liaison to the RRC programs was established to ensure that LEAs were not contacted twice and that nominations were co-ordinated between the CSSP and RRCs. The CSSP met with representatives of national groups including the National Association of State Directors of Special Education and the Council for Exceptional Children to clarify issues in each of the five areas and to solicit nominations of SEAs and LEAs with successful practices.

As each state was visited, additional LEAs were nominated by state directors of special education and their staffs. Each returned questionnaire was reviewed by CSSP and RRC staff. Descriptions or unique arrangements that implied effective, low-cost practices and general trends in service delivery were sought. This screening led to the selection of just over 100 sites for phone contact. Phone interviews were held with a key individual at the site, usually a local director of special education, for the purpose of clarifying questionnaire data and to select sites for full documentation. The following criteria were applied in selecting local sites for documentation visits.

1. The LEA believed its practice was effective.

2. The practice appeared to be within the law.

3. The practice resulted in role clarification among agencies.

4. The practice increased service in one or more of these areas:

    a. Quality
    b. Volume
    c. Speed
    d. Coverage.

5. The practice reduced redundant effort.

6. There was a positive fiscal impact of the practice; and/or

7. The practice had a mechanism for conflict resolution.

The CSSP conducted the majority of site visits. These were supplemented by Mid-South RRC visits and by reports prepared by other RRCs regarding sites for which another visit would be redundant. Site-visit reports were drafted, reviewed by both the CSSP and RRC staff, and sorted into one of the five issue areas based upon primary emphasis or impact. The final fifteen sites for this report were selected based on the seven criteria, on geographic distribution, and on replicability. All site reports were revised and approved by the site contact persons.

As of this writing, the CSSP is preparing a five-part series on policies and practices in its five issue areas. This report and the CSSP reports contain similar information. This document, however, has been prepared specifically to help local school district administrators plan strategies to work with other agencies in providing educational and related services.

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